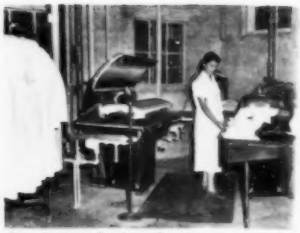
Canadian Hospital

Journal of The Canadian Hospital Association

May, 1960

Better quality work and fast return of linens to service is provided by this modern, efficient washroom equipped with (r. to l.) easy-to-use 36 x 54" Cascade Washer, 30" Solid Curb Extractor, 17" Monex Extractor and 36 x 18" Cascade Washer.

Two-Roll Streamline Ironer beautifully finishes the hospital's weekly flatwork volume of nearly 5,000 lbs. Two operators easily handle all work on a fast schedule.



One operator finishes all uniforms, gowns an other apparel on this fast, coordinated press unit of super-Zarmo and Super-Zarmoette Presses.

PROGRESSIVE PLANNING OF LAUNDRY HELPS HOSPITAL TAKE EXPANSION IN STRIDE.

Expert planning by The Canadian Laundry Machinery Co. periodically increased the laundry capacity of Cobourg District General Hospital, Cobourg, Ontario, but always with an eye to the future. As a result, when the hospital expanded from 35 to 100 beds, the laundry plans were ready. With the addition of several specific machines, and just two more people, Cobourg Hospital now has a modern, up-to-date laundry capable of efficiently handling all the work up to 125-bed capacity.

Naturally, Canadian representatives and engineers worked closely with the architect and the hospital administrative staff, making surveys and providing detailed layouts and specifications. This project is a typical example of the continuous, expert service that you, too, can expect from your nearby Canadian representative. Call him today, or write for complete information.

Canadian

The Canadian Laundry Machinery Company, Ltd., 47-93 Sterling Road, Toronto 3, Ontario.
Western Representative—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver.

Technician is setting controls for the assaying run. Picker equipment (left to right) Magnascaler, (below it) High Voltage Supply, Automatic Sample Changer with Detector, Readout Printer.

takes time and labor out of a tedious job

If you are doing blood-brain barrier studies in order to investigate how different drugs get into the brain, you will probably be using many rats, guinea pigs, or monkeys. Each of these test animals will ultimately have to be sacrificed for brain dissection. Then, if you have used Carbon^{14} or Phosphorus^{32} to tag the drugs, each brain section (cortex, cerebellum, etc.) will have to be counted. In such cases the use of an automatic sample changer not only saves many hours of a technician's time but also improves the accuracy of the measurement by furnishing printed data.

Picker can supply a highly reliable system for automatically counting up to 30 samples and for recording either the time required for each sample measurement to achieve a preset number of counts, or for printing both the counting time and accumulated counts for each sample.

The Automatic Sample Changer is representative of the comprehensive Picker line of quality nuclear instrumentation.

PICKER nuclear instruments

many models of

- scintillation probes
- focusing collimators
- mobile probestands
- high voltage supplies
- decade scalers
- ratemeters
- well counters
- flow counters
- spectrometers
- automatic sample changers
- recorders
- survey meters
- printing interval timers
- count and time printers
- accessories/sundries

Picker nuclear

this hallmark is dependable assurance of fine instrumentation, backstopped by the trained Picker national Service Organization. Picker X-Ray Engineering Ltd., 1074 Laurier Ave., West, Montreal, Que.

TRAVAD is the first disposable enema that takes the patient into consideration, by adding convenience to effectiveness . . . 18" of flexible tubing permits either self-administration by the patient in the sitting position or conventional administration in the left lateral or knee-chest position . . . is so gentle that the patient is practically unaware of the introduction of fluid . . . cleans more thoroughly and consistently than two, one-quart tap water enemas . . . can be administered, retained and evacuated in less than 10 minutes*

effectiveness plus convenience

the more pleasant, practical way to give an enema . . . nothing to assemble or clean up . . . pre-lubricated rectal tip . . . metal flow valve prevents spillage of fluid until time of administration

saves time . . . releases personnel for other duties . . . reduces work load . . . costs no more than less convenient units . . . saves storage space

Each 100 ml. contains: Sodium Dihydrogen Phosphate, 12 Gm. and Sodium Citrate, 10 Gr .

A product of Travenol Laboratories, Inc.,

Distributed in Canada exclusively by

INGRAM & BELL LIMITED
TORONTO
MONTREAL · WINNIPEG · CALGARY · VANCOUVER

*Weinstein, J. J.: Bowel Preparation for Anosigmoidoscopy with a Hydrogogue Enema. To be published.

T e Canadian Hospital Association is the fed ration of hospital associations in Canada and the Canadian Medical Association in c -operation with the federal and provinc al governments and voluntary nonpro t organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices:
25 Imperial St., Toronto 7, Ont.
Tel.: HU. 1-2244

Contents

May, 1960, Volume 37, No. 5

Cover picture—Hôpital St-François d'Assise, Quebec City.
(For Subscription Rates See Page 104)

Business Manager: Charles A. Edwards
Advertising Manager: Thomas L. Wells
Advertising Offices: 25 Imperial Street
Toronto 7, Ontario

Authorized as Second Class Mail, Post Office Depart., Ottawa.

NEW CURITY PACKAGING DISCOVERY!

NOW...A PRE-PACK THAT OPENS ASEPTICALLY

...*in one simple motion!*

New S-E Pack keeps dressing sterile from package to patient.
Opens without scissors or string–dressing never touches torn, unsterile edges.

An ingeniously simple wrap now gives you Cover Sponges that remain totally sterile—even during their removal from the package. There's no contact with hands or unsterile edges. Completely aseptic, at a time when strict adherence to aseptic technique is a main line of defense against hospital staphylococcus. 1, 2, 3, et. al.

In addition to much wanted safety, you have the much proven pre-pack efficiency that yields steady dividends in terms of time gained, labor spared and money saved.

For the latest—as well as the safest—in hospital dressings, see Curity.

1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

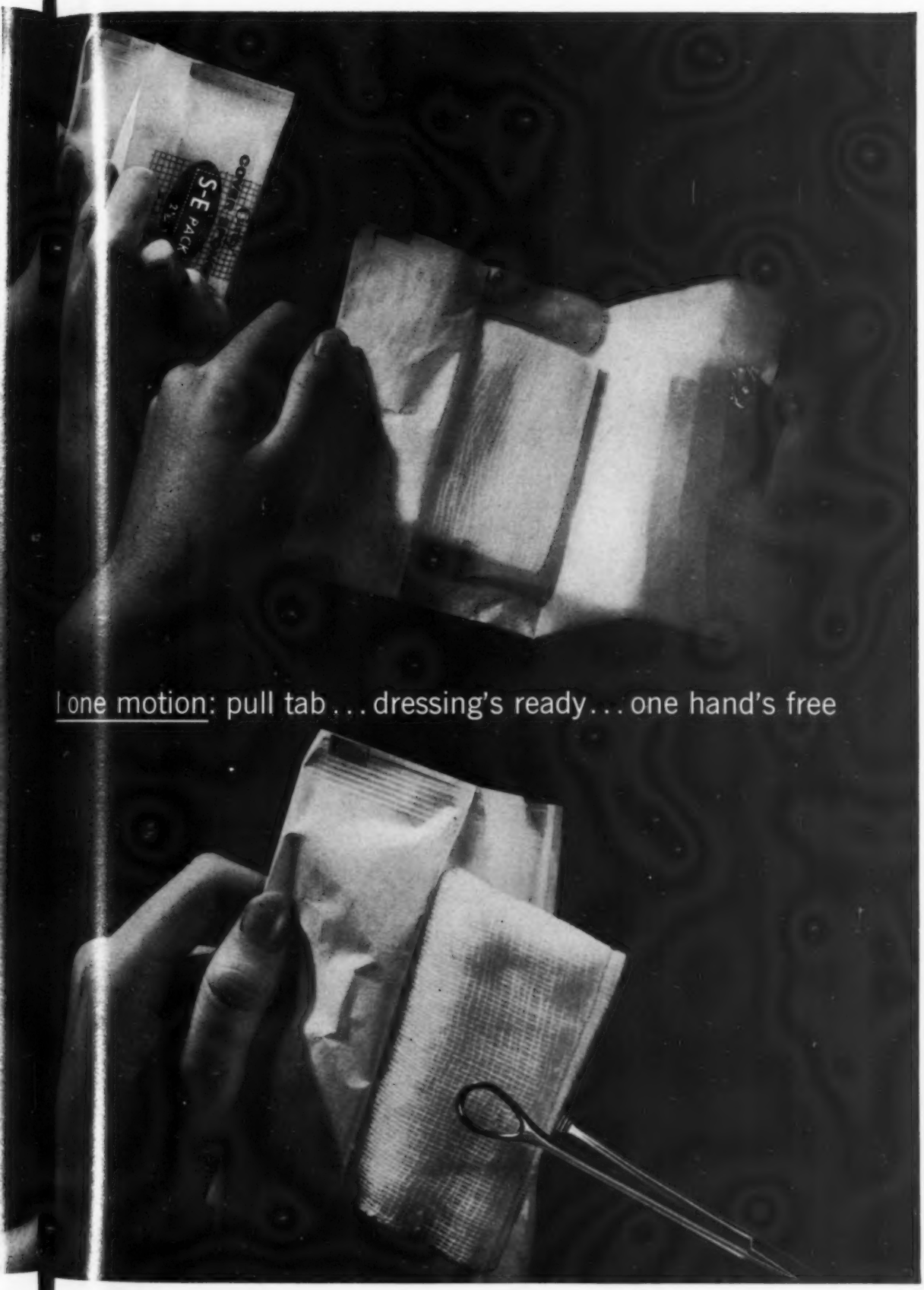
CURITY Cover Sponges now available in S-E Pack—no additional cost

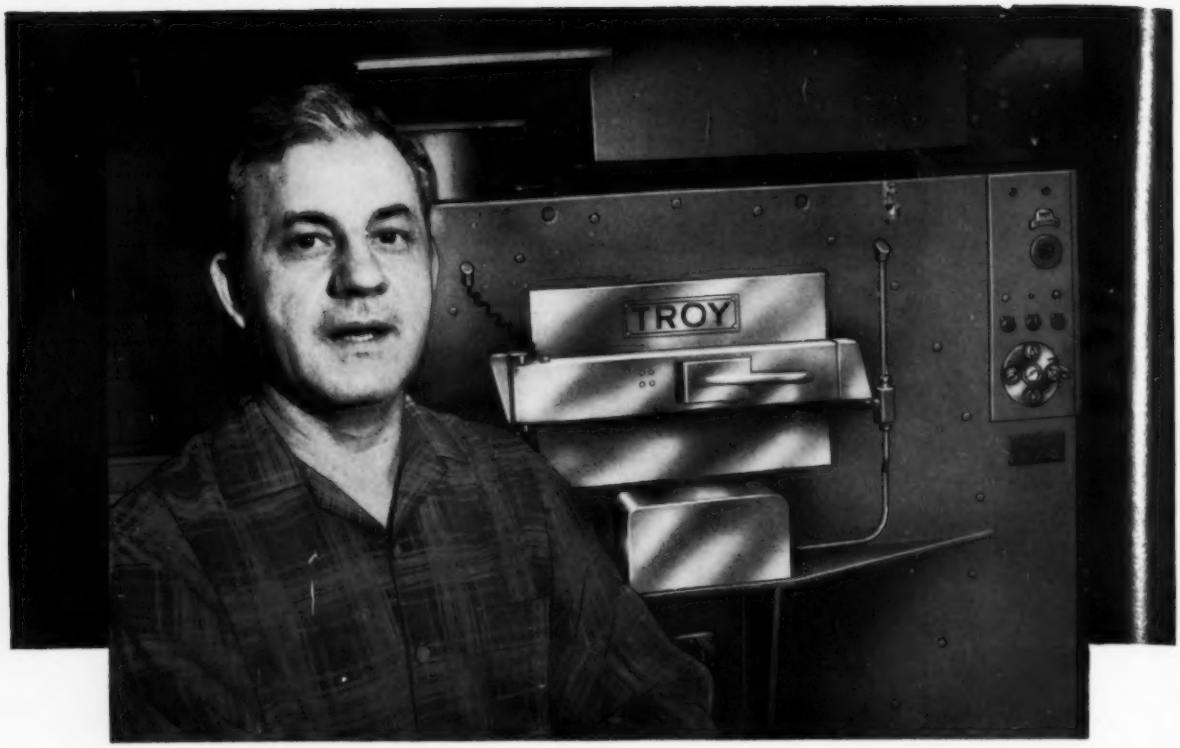
Curity TRADE MARK

S-E* PACK

*T.M.

THE KENDALL COMPANY (CANADA) LIMITED
BAUER & BLACK DIVISION


S-E PACK
one motion: pull tab . . . dressing's ready . . . one hand's free



Troy WX® washer-extractor pays for itself

A first person report by John Frantonius, Chief Engineer, Highland Park Hospital, Highland Park, Illinois.

"Our existing laundry facilities couldn't handle the extra laundry from a 35-bed Medical Pavilion acquired three years ago by the Highland Park Hospital Foundation. So it was done outside, at a cost of $7,200 a year. To lower this cost and increase our productivity to handle another 60-bed expansion, we purchased a 375 lb. TROY WX WASHER-EXTRACTOR, replaced a 40 lb. tumbler with a 100 lb. TROY Tumbler, and replaced a two-roll ironer with a 120 in., six-roll TROY SPEEDLINE Ironer.

"With our new TROY WX, we've increased our daily productive capacity 50.7%, slashed per load production time 22%, raised our total capacity 87.5%, and substantially reduced our production costs. In fact, the savings on Pavilion laundry costs alone *will more than pay for our new* TROY WX WASHER-EXTRACTOR!

"Laundry working conditions are improved, too. The Bifurcator fan on the TROY WX eliminates the rush of steam after extraction plus improving extraction so clothes come out *just damp enough to be put directly into the ironer*. The laundry stays cleaner because we're removing virtually dry clothes from our TROY WX . . . floors don't have to be mopped dry.

"We like the TROY WX features of spray-rinse suds removal and automatic dispensing of soap additives during cycle phases, too.

"We checked the products of three other manufacturers before purchasing, and we are very satisfied with our decision. We feel that we have received a superior product. The savings that are anticipated will pay for the TROY WX WASHER-EXTRACTOR in 2½ years."

Whether you're planning a new hospital laundry or an expansion of your present one, there's a TROY WX WASHER-EXTRACTOR to meet your needs most economically. Available in 25 lb., 100 lb., 200 lb. and 300 lb. capacities.

Troy® WX WASHER-EXTRACTOR
T.M.
100 Lbs. • 200 Lbs. • 375 Lbs.

Write Dept. CH-560 for detailed bulletin

LAUNDRY MACHINERY
(Canada) Ltd.

132 McCaul Street Toronto, Ont.
Room 205 Heagle Building, 1606 Centre St. N.
Calgary, Alberta.

HIGH-ENERGY RADIATION

maxitron 2000

high dose rates at low cost per rad

2-MILLION VOLT X-RAY UNIT—the culmination of more than half a century's experience with radiation. Maxitron 2000 is the most powerful in the complete range of x-radiation therapy sources offered by General Electric.

With the Maxitron 2000, high-energy radiation is generated *electronically* . . . dose rate never decreases due to decay. No source—isotopic or otherwise—compares in maintenance savings. Records of medical centers show that not a single x-ray tube has failed in the entire decade since the first unit was installed! At dose rates provided by the Maxitron 2000, maintenance cost for delivery of 1000 rads to a tumor at 10-cm depth (100-cm square field) *has averaged only pennies!*

For full facts on any range of x-ray therapy equipment, see your G-E x-ray representative. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room 1003F.

Maxitron is a G.E. registered trademark.

maxitron 1000

MILLION-VOLT X-RAY UNIT—Maxitron 1000 super-voltage therapy unit combines high-energy output, easy operation and duplication of dosage—thanks to *electronically generated* radiation. Here again General Electric quality has reduced maintenance per thousand rads to just *pennies.*

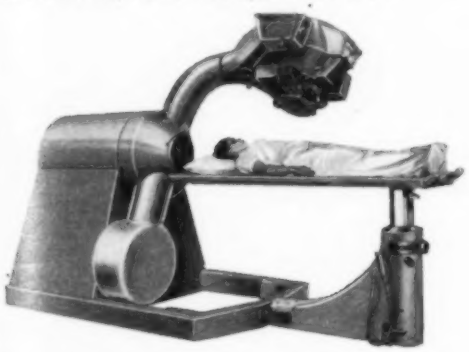
Progress Is Our Most Important Product

GENERAL ELECTRIC

ISOTOPE TELETHERAPY

Select from seven cobalt and caesium units

General Electric sells, installs *and services* a complete range of ECL isotope teletherapy equipment, capable of technics from conventional fixed-beam irradiation to complex rotational patterns. All have fail-safe shutters that close automatically in event of power failure.



THERATRON F (shown)—200 r/m/m maximum cobalt-60 source capacity. For fixed- and moving-beam teletherapy.

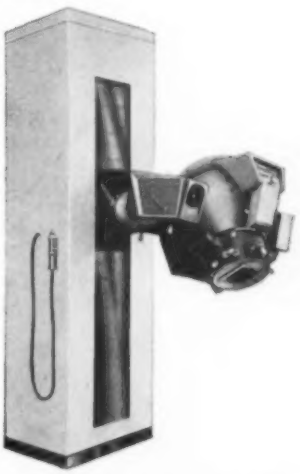
THERATRON B—165 r/m/m maximum cobalt-60 source capacity. Fixed- and moving-beam capabilities.

THERATRON C-II—50 r/m/m maximum cobalt-60 source capacity. For both fixed- and moving-beam technics.

THERATRON JR. (shown)—50 r/m/m maximum cobalt-60 source capacity. Fixed- and moving-beam teletherapy provisions.

Progress Is Our Most Important Product

GENERAL ELECTRIC



ELDORADO SUPER G (shown)—200 r/m/m maximum cobalt-60 source capacity. For fixed-beam teletherapy.

ELDORADO G—50 r/m/m maximum cobalt-60 source capacity. Fixed-beam teletherapy unit.

CAESATRON (shown)—1300-curie caesium-137 source capacity. Fixed-beam technic.

• *See your G-E x-ray representative for complete details on equipment for x-ray and isotope therapy. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room 1009.*

Notes About People

O.H.S.C. Appointments

Two assistant-directors, G. Frederick Surphlis, C.G.A., and Robert A. Robertson, have been named to work with the recently appointed Director of Hospital Insurance, R. E. Foster. Mr. Robertson is succeeded as field services manager by John J. Mahoney. All three were associated with the Ontario Hospital Association and its Blue Cross Plan for many years before transferring to the Commission in 1958.

The new Assistant comptroller is Walter O. Hardacre, who has been senior consultant in finance for the past 16 months. This latter post is now taken by Bruce W. Varty who is succeeded as special projects consultant by Gordon E. Fetherston.

Nursing Staff Changes at Toronto General

It was recently announced that E. Jean McKay, assistant director of nursing service is assuming the newly created position of assistant director for staff education. She will organize and direct the in-service program for professional and auxiliary nursing personnel. The present nursing service supervisor of the central building, Jean Dodds, has been appointed assistant director for nursing service and will be responsible for the nursing service in all areas of the hospital.

Hospital Insurance Organizers Resign

Dr. C. Lloyd Francis and John E. Sparks, who have been members of the research and statistics division of the Department of National Health and Welfare for many years have recently resigned. Dr. Francis will devote full-time to business interests and to his municipal activities as alderman of the city of Ottawa. Mr. Sparks will become secretary of the advisory planning committee on medical care recently established by the Province of Saskatchewan.

Dr. Francis, as the principal research officer of the federal department, and Mr. Sparks as the supervisor of the hospital and medical care insurance section of the division, played an outstanding part in the development of the nation-wide hospital insurance program governed by the Hospital Insurance and Diagnostic Services Act of 1957, and in many other major research activities of the Department.

New Post in London

Dr. A. H. Neufeld of Queen Mary Veterans' Hospital, Montreal, P.Q., has recently been appointed professor and head of the Department of Pathological Chemistry at the University of Western Ontario and at Victoria Hospital, London, Ont. Dr. Neufeld is a graduate of the University of Manitoba and McGill University. He is well known for research in the field of metabolic and endocrine diseases and is a former editor of the Canadian Services Medical Journal.

Appointments at Burlington

Marie E. Hudson, B.Sc., R.N., has been appointed director of nursing for Burlington's new Joseph Brant Memorial Hospital. Formerly director of nursing at Hamilton General Hospitals, Miss Hudson is currently assistant professor of the School of Nursing at the University of Western Ontario, London, Ont.

Former Regina Anaesthetist Dies

Dr. Beverly C. Leech, O.B.E., died recently in Nanaimo, B.C. Appointed as director of the department of anaesthetics at the Regina General Hospital in 1929, he held this post until his retirement four years ago. At the outbreak of the second world war he mobilized Regina's 10th field ambulance for active service and took the unit to England in 1940. He was a past president of the Canadian Anaesthetists' Society and was one of the founders of the Regina branch of that society.

Scholarship

One of ten winners of scholarships for the American Hospital Association's 12th annual course in hospital housekeeping is Mrs. Frieda Schoellkopf, executive housekeeper, Hotel Dieu Hospital, St. Catharines, Ontario. Huntington Laboratories, Inc., Huntington, Indiana, gave the ten scholarships of $350 each.

O.H.A. Appointment

J. G. Helm has been appointed manager of the newly created insurance and pensions division of the Ontario Hospital Association. Mr. Helm joined the Blue Cross division of the Association in 1946 and served as chief accountant to supplementary coverage during conversion of Blue Cross. Since January, 1959, he has been associate manager, Internal Services.

Toronto Physician Wins Research Grant

Dr. John R. Evans, chief resident physician at the Toronto General Hospital, has been appointed a Markle Scholar in medical science by the John and Mary R. Markle Foundation of New York. The scholarships carry a $30,000 grant over five years to supplement the scholar's support and aid his research. These grants have been made annually since 1948.

During the five-year period, Dr. Evans will lecture in internal medicine and undertake a heart research project.

R.N.A.O. President

Ella M. Howard, director of nursing of the New Mount Sinai Hospital was acclaimed president of the Registered Nurses Association of Ontario at the recent April session in Toronto. She succeeds Margaret P. Morgan of Hamilton. Mrs. Blanche Duncanson of the new Nightingale School of Nursing, Toronto, became first vice-president.

Professorship Grant Honours Late Surgeon

Dr. William Edward Gallie, Toronto surgeon, former dean of the faculty of Medicine at the University of Toronto, who died last September, will be honoured by the establishment of a visiting professorship in Canadian medical schools. This has been made possible by a $6,000 grant from the R. Samuel McLaughlin Foundation. The professorship will be known as the McLaughlin Foundation Edward Gallie Visiting P o-

(continued on page 20)

TO SAVE VALUABLE NURSES' TIME

Wash-'n-Dri

individual moist towelettes

. . . Combine superior cleansing properties with prolonged antiseptic action

Wash-'n-Dri is an individually packaged, moist, antiseptic tissue, for washing the hands, face and all other body areas without soap, water or the use of a wash cloth and towel.

The antiseptic action of Wash-'n-Dri is provided by the incorporation of 0.042% benzalkonium chloride which leaves a germicidal film on the skin surface.

Wash-'n-Dri cools, cleanses . . . dries quickly by evaporation, but includes propylene glycol which leaves the hands and face soft and smooth. Can be used on the most delicate skin with absolute safety.

Wash-'n-Dri is a timesaver for the hospital staff . . . a welcome convenience for the patient. They can be placed in the bedside cabinet for use after the bed pan and urinal . . . on meal trays for a refreshing "after-meal" wash-up and by maternity patients to disinfect the hands prior to infant nursing.

Wash-'n-Dri towelettes are 6" x 8" in size, folded in a 3" x 2¼" heat-sealed aluminum foil envelope. Available in boxes of 100 and cases of 1,000 (10 boxes of 100).

FREE!

BE CONVINCED—TRY WASH-'N-DRI YOURSELF!
ASK YOUR I&B REPRESENTATIVE OR CONTACT OUR NEAREST BRANCH FOR A SPECIAL COMPLIMENTARY PACKAGE

DISTRIBUTED TO CANADIAN HOSPITALS EXCLUSIVELY BY

INGRAM & BELL LIMITED

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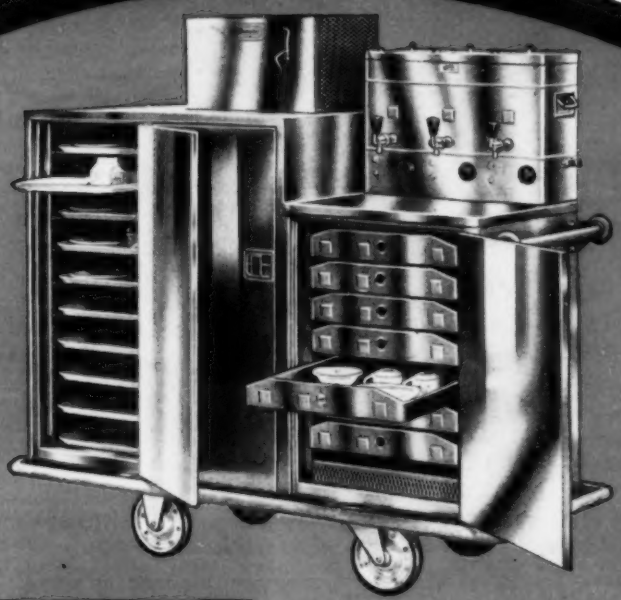
MONTREAL • WINNIPEG • CALGARY • VANCOUVER

Shampaine Electric

SUPER-MEALCART

DELIVERS "DINING CAR" LUXURY AND EFFICIENCY

The true centralized tray service system



NEW! "EASY-SEAL" LATCHES. Slam the doors or touch them with your finger tips . . . they close easy, seal tight every time. Latch has only three working parts.

LUXURY FOR PATIENTS

It pleases patients with "little" things that mean so much: pre-heated coffee cups; choice of beverages and soups (hot or cold); crisp salads; cold desserts . . . to match piping hot meats and vegetables. NO COMPLAINTS ABOUT "INSTITUTIONAL" FOOD!

EFFICIENCY FOR YOU

1. Unobstructed, counter-height set-up area with exclusive "step-down" feature. Takes trays up to 15½"x 20½".

2. Refrigerated tray compartments . . . cold items on trays ready to go. Slides easily removed to clean compartments. 3¾" between slides allows space for ½ PINT MILK CARTONS.

3. Heated drawers (185°) . . . each holds three 9" plates, three 5½" plates with hot foods ready for trays. Room for three cups, too. **Only method that guarantees hot coffee.**

4. Holdover refrigeration system maintains low temperature for two hours without current. **No blowers to dry out and wilt food!**

5. Available in 20- and 24-meal sizes.

6. All stainless steel, double-walled, fully insulated. Recessed doors on piano hinges with exclusive **"Easy Seal" Latches.**

7. REMOVABLE BEVERAGE BAR. Insulated wells for hot and cold drinks and soups. Use separately on utility truck for between-meal serving or in doctors' lounge (see below).

Shampaine
ELECTRIC CO

615 E. First Avenue • Roselle, New Jersey
A DIVISION OF SHAMPAINE INDUSTRIES, INC.

THE TABLE OF TOMORROW—HERE TODAY...S-1501

SURG-A-MATIC® BY SHAMPAINE

SURG-A-MATIC brings you many features that set new standards for major operating tables.

PUSH-BUTTON SHIFT—Ultra-convenient push buttons select all positions—conventional or extreme . . . including single adjustment proctoscopic, complete flex, reflex and kidney elevator. Push buttons eliminate visual attention.

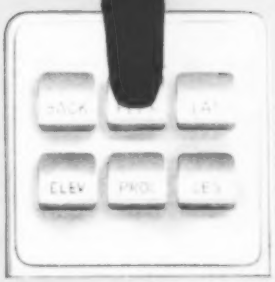
HEAD END CONTROL—All controls face anesthetist . . . outside draped and sterile field. Anesthetist remains seated. No search at sides of table to check indicators or reach controls.

NEW BASES—Motorized or hydraulic . . . with new features for smoother, easier operation. No external housings.

FAST ACTING SIDERAIL CLAMPS—Eliminate broken or easy-to-lose setscrews. Accessories attached or detached with minimum effort and time.

NEWLY DESIGNED CRUTCH SOCKETS—Quick acting friction lock clamps speed adjustment of leg holders. Self-locking socket holds rod in any position . . . sockets easily removed.

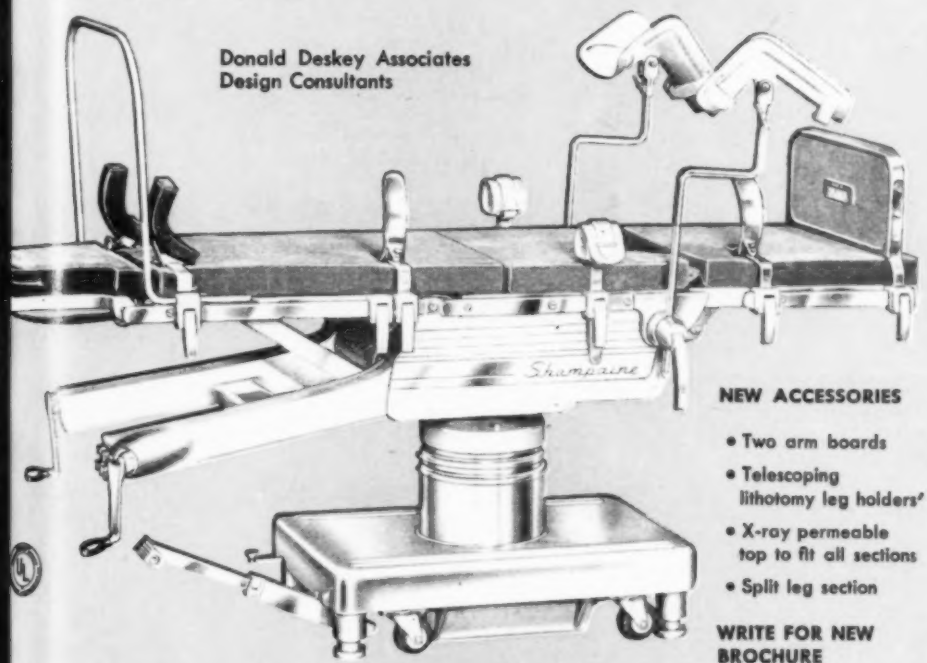
FEATURING EXCLUSIVE PUSH-BUTTON SHIFT



JUST PUSH A BUTTON AND TURN HANDLE AT RIGHT TO REACH ANY OPERATIVE POSITION

Left handle controls independent Trendelenberg adjustments (maximum Trendelenberg in 22 turns). See new Shampaine positions below.

Donald Deskey Associates
Design Consultants



NEW ACCESSORIES

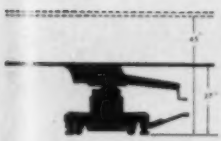
- Two arm boards
- Telescoping lithotomy leg holders'
- X-ray permeable top to fit all sections
- Split leg section

WRITE FOR NEW BROCHURE

Shampaine COMPANY

1920 S. JEFFERSON • ST. LOUIS, MO.

a SHAMPAINE Industry



SURG-A-MATIC provides table top heights from 27" minimum to 45" maximum.

SURG-A-MATIC provides kidney elevator adjustment off push-button shift.

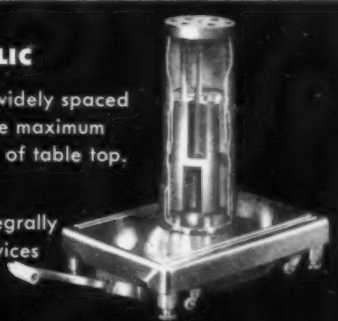
SURG-A-MATIC provides complete 139 degree flex.

SURG-A-MATIC provides single adjustment proctoscopic position.

NEW BASES—MOTORIZED OR HYDRAULIC

Table top is supported by three widely spaced rods within pedestal. They provide maximum support to eliminate lateral whip of table top. No exposed keyways.

Flat stainless steel shield has integrally formed footrests to eliminate crevices and assure easy cleaning.



Entire table UL Approved for use in class 1, group C atmosphere. Motor concealed in base — no external housings.

Downward strokes of pump pedal immobilize table on hydraulic self-leveling floor jacks. Upward pressure on pedal retracts floor jacks... table is then on easy to move three-inch ball bearing casters. Jacks provide firm support and are self-leveling on normal operating room floor.

Now...
Micro-Filtered Air
for the
No. 1 Croup Tent

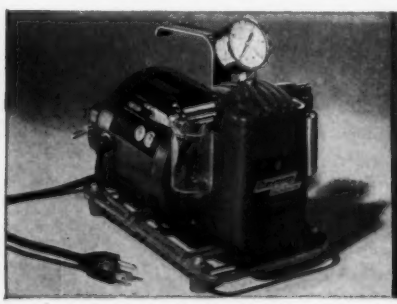
Continuous recirculation of fresh, cool, moisture-saturated air, an exclusive feature of the CROUPETTE®, "is important in the care of babies with lower respiratory infections."[1]

First "cool vapor" croup tent, the CROUPETTE is used in more than 83% of all hospitals in the U.S. accredited for residency training in pediatrics, including all those affiliated with U.S. medical schools. Compact, portable, easy to set up or store, with no moving parts, the CROUPETTE is as simple to operate and maintain as it is clinically safe and efficient.

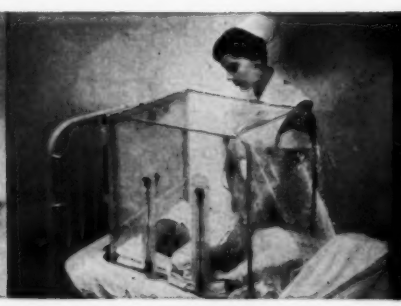
Now, by means of the new AIR-SHIELDS DIA-PUMP® with MICRO-FILTER, compressed air to operate the CROUPETTE can be kept virtually pathogen-free. Easy to carry, the DIA-PUMP is quiet, oil-free and unconditionally guaranteed for one year.

1. Kirkwood, E. S.: Nursing World 129:8, 1955.

The CROUPETTE and new DIA-PUMP with the unique MICRO-FILTER are compact, and easy to carry.



DIA-PUMP compressor (Model EFC), for continuous operation at low cost, delivers MICRO-FILTERED air at controlled positive pressure to 30 pounds per square inch.



Visibility, accessibility and simplicity are CROUPETTE features. Cool, MICRO-FILTERED, moisture-saturated air provides ideal atmosphere for therapy of respiratory infections.

THE **Croupette®** cool-vapor and oxygen tent by

Ontario, Quebec and the Maritime Provinces

AIR-SHIELDS CANADA, LTD.

8 Ripley Ave., Toronto 3, Ont. Telephone: Roger 6-5444

Manitoba, Saskatchewan, Alberta and British Columbia

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American Hospital Supply Corporation (Canada) Limited

Winnipeg • *Edmonton* • *Vancouver*

now

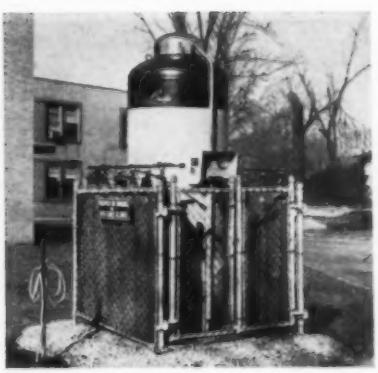
...LIQUID OXYGEN FOR ALL GENERAL HOSPITALS ...25 BEDS OR LARGER!

EVERY GENERAL HOSPITAL in Canada — from 25 beds to the largest — can have the benefits of a "LINDE" liquid oxygen system.

An experienced LINDE representative can tell you quickly which unit best suits your use. Rate of monthly oxygen consumption and your geographical location are the determining factors in selecting the proper unit for your hospital. If you do not have piping, the LINDE representative can advise you how best to adapt your hospital to receive "LINDE" liquid oxygen service.

Learn how you can take advantage of LINDE'S more than 40 years' experience in the Canadian oxygen business. Call your nearest LINDE representative or distributor. Or write Linde Company, Division of Union Carbide Canada Limited, 40 St. Clair Avenue E., Toronto 7, Canada.

Surprisingly compact, this 90 VCC unit holds 90,000 cu. ft. of oxygen. It's a relatively small package because at atmospheric pressure liquid oxygen in its gaseous state would require 862 times more storage space.



One of the most popular storage units is LINDE's new AT-25. It holds 25,000 cu. ft. of oxygen, yet fits in an area only five feet square.

Both portable and compact, the LC-3 container can be moved about by one man—yet holds 3000 cu. ft. of oxygen, the same as 12 conventional cylinders. LC-3's can be used at the bedside or manifolded to provide a continuous supply to the piping system.

LINDE COMPANY

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Notes About People

(continued from page 14)

fessorship in the Royal College of Physicians and Surgeons of Canada.

It is planned to select a distinguished scholar in any one of the clinical fields from any country in the world, to spend at least a month in Canada. He will visit one or more Canadian medical schools, lecturing, teaching and exchanging ideas with staff, research workers and students. The college has established a joint committee with representatives of the Association of Canadian Medical Colleges to select the first visiting professor and decide the schools to be visited.

Commission Member Honoured

Recognition of 14 years of service as a member of the Colchester Hospital Commission was given to Rufus E. Dickie of Stewiacke, N.S., at the recent annual meeting of the commission. Mrs. Daisy Fisher, who succeeds Mr. Dickie as chairman, presented him with an illuminated scroll.

V.O.N. Post

It was recently announced that Miss Jean C. Leask of Toronto is appointed director in chief of the Victorian Order of Nurses for Canada and will take up her duties in September. Miss Leask succeeds Christine Livingston, lately retired.

Appointment at McGill

Miss Mary Richmond, director of nursing at Royal Jubilee Hospital, Victoria, B.C., for the past nine years, has been appointed director of nursing studies at McGill University.

• Formerly secretary-treasurer at Hôpital St-Louis de Windsor, Paul-Aimé de Bellfeuille has now been named administrator of this hospital.

• Recent appointments in the faculty of medicine at Laval University, Quebec, are those of Dr. Léo Gauvreau, bacteriologist, as full professor, and Dr. Paul Genest, pathologist, professor agrégé.

• Mrs. Yolande Taylor, administrative resident at the women's pavilion of the Royal Victoria Hospital, Montreal, P.Q., has been granted leave of absence to accept the post of Secretary to the Hospitalization Service of the Quebec Inquiry Commission on Hospitalization, recently established by the provincial government.

• Mr. E. J. Davies, formerly assistant administrator at Verdun Protestant Hospital, Montreal, is now superintendent of the Halifax County Hospital, Cole Harbour, N.S. Mr. Davies is replaced at the Verdun Protestant Hospital by Mr. E. J. Campbell who was previously hospital secretary at St. John's Sanatorium, St. John's, Newfoundland.

• Dr. J.-E. Gaudet has recently been elected president of the medical board at Saguenay General Hospital, Arvida, Que. He succeeds Dr. Roméo Gagnon who becomes medical director of the hospital.

(concluded on page 28)

Adams Silicone Skin Spray prevents bed sores and skin irritations

Now, Clay-Adams has made available a product which provides the skin-soothing properties of silicone and the bacteriostatic action of hexachlorophene *in an aerosol spray.*

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Notes About People

(concluded from page 20)

• Norman A. Hall, chairman of Shaunavon Union Hospital Board, has been named as the recipient of the Smith Walshaw Memorial award. This award is given annually for distinguished service to Saskatchewan's Hospitals and is made by the Board of Directors of the Saskatchewan Hospital Association.

• J. Jarvis of Swan River, Manitoba, has been appointed administrator of the Swan River Valley Hospital.

• Dr. M. S. Acker, D.P.H., until recently director of the co-ordination and planning branch of the Saskatchewan Department of Public Health, has been appointed director of the Regional Health Service Branch.

• Oliver G. Pratt, executive director of the Rhode Island Hospital, Providence, has been named to receive the American Hospital Association's distinguished service award for 1960.

• Until the formation of a definite medical board at Hôpital du Christ-Roi in Quebec City, Dr. David Beaulieu has been appointed temporary medical director. He is also medical director and administrator of the Sanatorium Ross in Gaspé.

• Dr. A. S. Cowie of Fredericton has assumed on a part-time basis the duties of medical officer in charge of the medical assessment of hospital claims for the New Brunswick Hospital Services Commission.

• Mr. Silvio R. Lamattina has been appointed administrator of the Monsour Hospital and Clinic, Jeannette, Pennsylvania. He was formerly acting administrator of the North Country Hospitals Inc. and is a graduate of the Canadian Hospital Association's two-year course in hospital organization and management.

U.S. Grant to Toronto Cancer Team

A team of five Toronto doctors, studying the relation of virus to tumors in animals and man, has received a $290,520 research grant from the U.S. Health, Education and Welfare Department. The project is being carried out at the Ontario Cancer Institute in the Princess Margaret Hospital by Dr. A. W. Ham and his associates.

Team to study Hospital Insurance

A seven-man commission has been appointed to investigate a possible insurance plan for Quebec. Chairman of the commission is Gérard Favreau of Montreal and other members represent industry, the church, labour and medicine. Included is Dr. Gérald LaSalle of Montreal who is executive director of the Quebec Hospital Association. The government has instructed the commission to establish, without delay, the total debt of all hospitals and the influence this debt has on the cost of hospital services.

Hospital Magazine

New Outlook, published by the patients and staff of the Saskatchewan Hospital at North Battleford, covers not only the North Battleford hospital's news, but the field of mental health in general. This magazine is read with interest, not only by the hospital patients and staff, but by mental health workers throughout Canada, the U.S., and abroad. —*Saskatchewan News*

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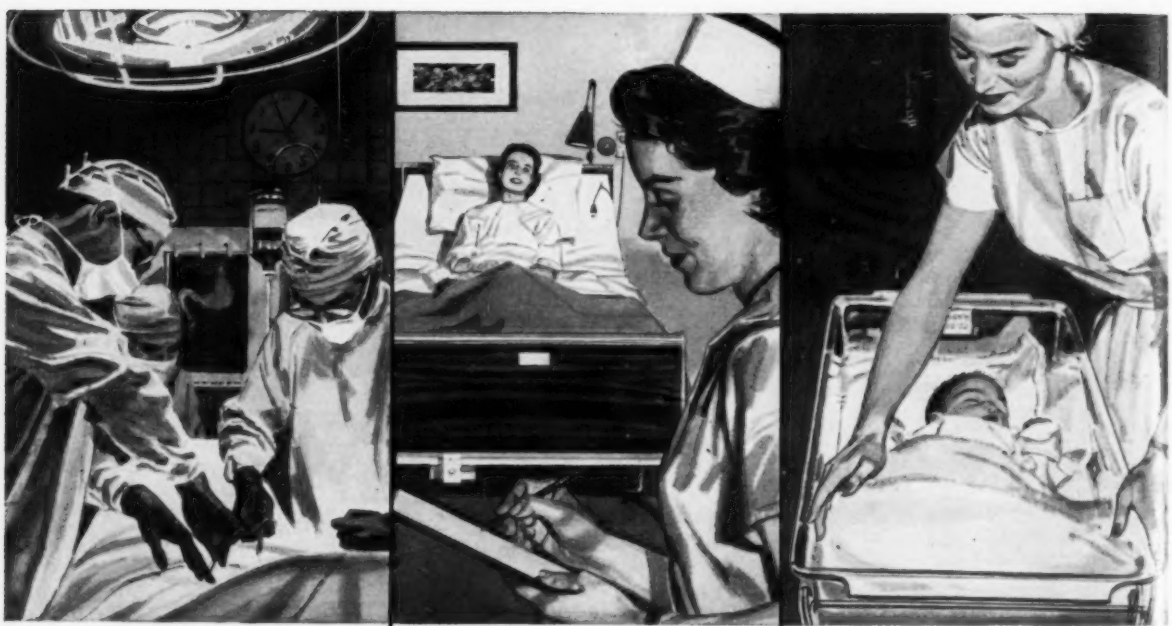
The Honeywell Electronic Air Cleaner removes 95% of all dirt that passes through the air handling system



The accumulation of germ-laden dirt and dust in the ventilating and air conditioning ducts creates a hidden menace in the heart of the hospital. It is *vital* to keep these areas as free of dirt and dust as possible.

Dirt and dust in ducts can mean the presence of disease-causing bacteria and virus. The Honeywell Electronic Air Cleaner traps dirt and dust particles as small as 1/25,000,000 of an inch.

The Honeywell Air Cleaner is the most practical method for obtaining clean air. It is *6 times as effective* as ordinary mechanical filters, and is a permanent air cleaner, requiring only periodic washing to maintain maximum efficiency.

A Health Menace: HIDDEN DIRT—In ventilating ducts, dirt accumulates out of sight and out of reach. As the illustration above indicates, this hidden dirt creates an unsanitary condition in the heart of the hospital.

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Of course, dirty ducts are only a *part* of the cleanliness picture in the hospital. Everyone knows that hospitals are scrubbed clean many times a day. But to effectively combat this important *airborne dirt* problem—and make your ventilating air and air conditioned air as clean as possible—you can depend on the Honeywell Electronic Air Cleaner.

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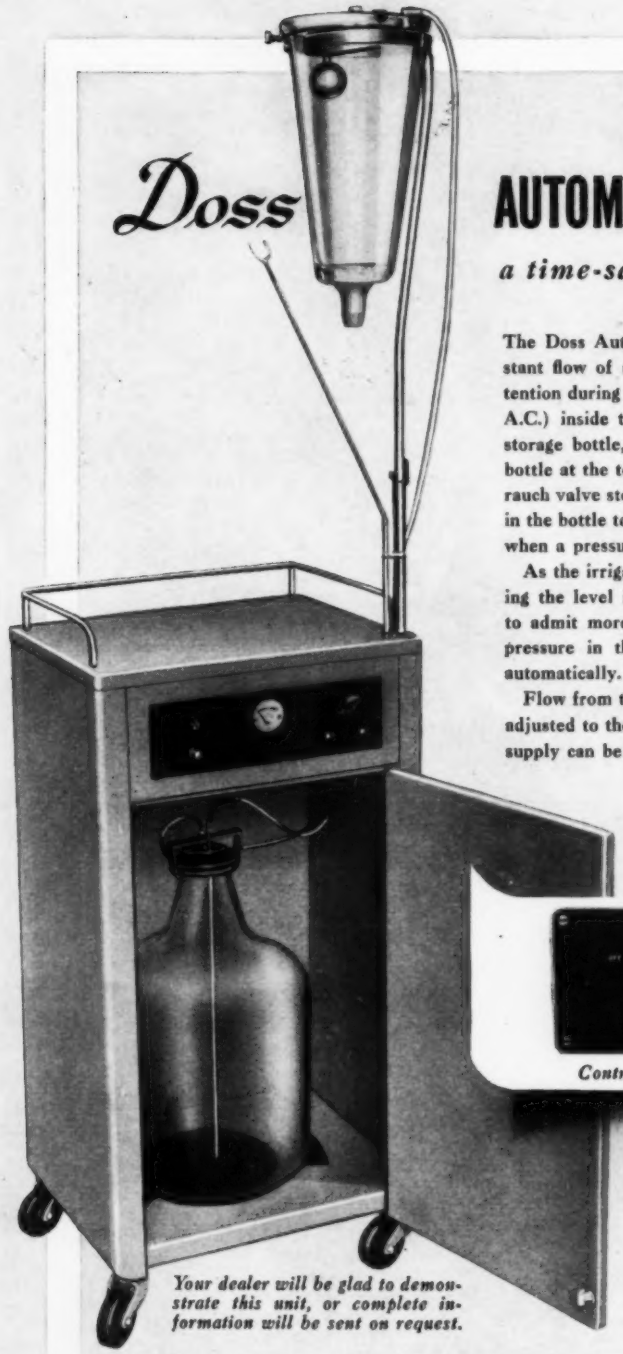

The Doss Automatic Percolator provides for the constant flow of an irrigating solution, with minimum attention during use. An electric pump (115 volt, 60 cycle A.C.) inside the cabinet builds up air pressure in the storage bottle, forcing the solution into the percolator bottle at the top of the unit. When this is filled, a Weyrauch valve stops the flow of water, causing air pressure in the bottle to increase until it reaches 3½ to 4 pounds, when a pressure-sensitive switch stops the pump.

As the irrigating solution flows to the patient, lowering the level in the percolator bottle, the valve opens to admit more solution. This, in turn, reduces the air pressure in the storage bottle, and the pump starts automatically.

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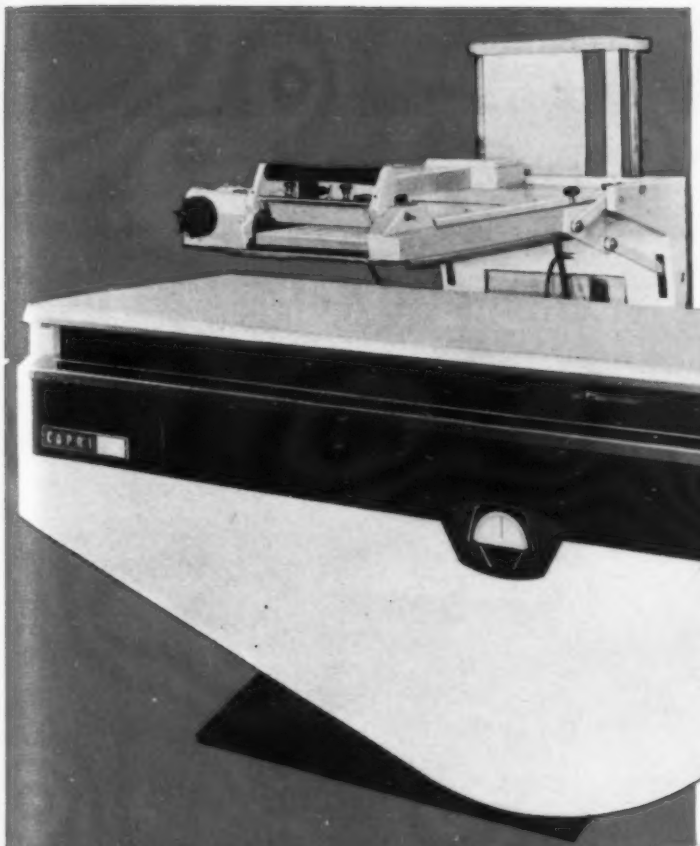

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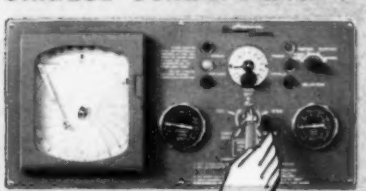

Eye level Control Panel includes Indicating — Recording — Controlling Thermometer and Cyclomatic Control. Simple, direct and positive, Cyclomatic Control begins timing when the selected temperature is reached, sterilizes, exhausts, and dries the load . . . AUTOMATICALLY. Saves steps and time for the operator, materials and steam for the hospital, and worry and uncertainty for the staff.

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W. Douglas Piercey, M.D., Editor

Canadian Hospital

Obiter Dicta

Blessings on the County of Peel

MANY hospitals in need of enlargement, major renovation, or complete replacement find it difficult to proceed because of a lack of funds. Even with the federal and provincial construction grants, a large sum of money must be raised locally. Sometimes this is done through fund-raising campaigns—with success in certain large cities; but in other parts of the country such campaigns have here and there met with dismal failure.

An increasing number of hospitals are aided in their construction financing through municipal sources. In many cases the hospital is owned by a single municipality. In others, particularly in the western provinces, hospital districts are formed consisting of several municipalities, all supporting the hospital from municipal tax funds.

A recent by-law of Peel County in Ontario—a county whose population is increasing rapidly with a resulting increased demand for hospital services—provides that the county shall make a grant to a hospital board to assist in construction of a hospital in the said municipality of $8,000 per bed, where it is established to the satisfaction of the county that the cost per bed is not less than $12,000. Where the cost per bed is less than $12,000, the Council will also make a grant of $8,000, less the amount by which the cost is under $12,000. Where the cost per bed is in excess of $12,000, the county shall make a grant of an amount exceeding $8,000 providing the Council of the County of Peel is satisfied the hospital board requesting the grant has exhausted all other sources of obtaining funds, and providing further that the Council of the County of Peel is satisfied that costs in excess of $12,000 are justified by special circumstances.

This action by the County Council of Peel has been lauded as a most progressive step toward ensuring that residents of the county receive adequate hospital care. Both the Ontario Hospital Association and the Ontario Hospital Services Commission have hailed the move as an answer to one of the most serious problems facing trustees today. Peel County's new system of grants is not meant to replace personal and corporation gifts, but to ensure that once these sources have been exhausted to the fullest extent, the county's grant, along with federal and provincial grants, will guarantee that the balance of funds required to finance and equip new hospital units will be available. The new legislation was recommended by the Council's Finance Committee after a long study of hospital problems throughout the county. Money needed for required hospital construction will be contained in the county's general budget and levied against the county's eleven municipalities. It is considered that this legislation was the only fair way of distributing hospital costs among all the people in the county.

It is of interest that the action taken by Peel County Council is along the lines of that recommended by the Canadian Hospital Association. In a submission which this association made to the Minister of National Health and Welfare in September 1957 (See *Canadian Hospital* November 1957), it was suggested that hospital construction costs be borne by the three levels of government equally, on a one-third of cost basis. While the formula in the case of Peel County differs from that laid down in our brief, we believe that, except in a few larger cities, the raising of money for hospital construction will more and more depend on initiative at the local municipal level.

C.H.A. Assembly Meeting, 1960

AT the 15th Biennial Meeting of the Canadian Hospital Association, held in Montreal in May of last year, it was decided to hold annual meetings of the Assembly which is the association's governing body. The Assembly is comprised of delegates appointed by associations and conferences which are active members of the association. The C.H.A. has no per-

sonal members. The 1960 meeting is being held at the Park Plaza Hotel in Toronto this month, May 23, 24, 25. The 16 active members of the association will be represented by 37 voting delegates and it is also expected that a number of alternates will attend the meeting.

The main purpose of this meeting is to conduct business pertaining to the national association. Reports will be presented by S. W. Martin, Toronto, president; Dr. John E. Sharpe, Toronto, treasurer; Dr. Harvey Agnew, chairman of the Committee on Education; and Walter W. B. Dick, chairman of the Committee on Accounting and Statistics. Charles A. Edwards will report on *Canadian Hospital* and the executive director will discuss the activities of the association during the past year.

A highlight of the first day will be an address by the Hon. J. Waldo Monteith, Minister of National Health and Welfare, and the Minister will also officiate at the formal opening of the new C.H.A. office building that evening. On Tuesday, Dr E. H. Lossing, Principal Medical Officer, Health Insurance, of the same department, will give a progress report on the national health insurance program. Dr. G. E. Wride, Principal Medical Officer, Health Grants, will outline the present national health grants. Dr. E. J. Young, Deputy Director, Civil Defence Health Services, will speak on organizing for emergency measures; and John Davis, Chief, Institutions Section, Dominion Bureau of Statistics, will review hospital reporting schedules. The third morning has been set aside for an exchange of information between associations and time has been provided on the program for discussion of hospital accreditation and the accreditation of schools of nursing.

Following the main sessions, on Thursday, full-time association secretaries have been invited to convene at 25 Imperial Street. They will discuss ways and means of improving communications between and co-ordinating the activities of the hospital associations.

Approval of Schools for R.T.'s

THE use of x-rays in diagnostic and therapeutic procedures is commonplace in the hospital today and we sometimes forget that they are a comparatively recent addition to the healing armamentarium. While x-rays were discovered in 1895, the wide use of them has developed only during our own lifetime. As diagnostic and radiotherapeutic procedures become more complex, the need for highly trained technicians increases. To-day the technician requires a thorough knowledge and understanding of the basic and applied principles of radiation, basic sciences and technique, as well as the problems inherent in dealing with sick people.

The development of a training program through the efforts of the Canadian Society of Radiological Technicians and the Canadian Association of Radiologists is outlined on page 78. From this it is apparent that much has been done since the organization of the C.S.R.T. in 1943 to improve and standardize the training of technicians; and the close co-operation between the members of these two societies is notable.

At the request of the C.A.R. and the C.S.R.T., the Canadian Medical Association last year accepted responsibility for approving hospital schools for the training of radiological technicians—as it has long done for medical interns and laboratory technologists. A standing committee for this purpose was established and "Bases of Approval" agreed upon. The prime objective of the current program is to provide a national standard of training at the highest attainable level. The new standards supercede but incorporate earlier minimal standards and they apply to teaching personnel, the physical facilities of the department, and the organization of theoretical and practical training.

Accreditation of Nursing Schools

WHEN the Canadian Nurses' Association meet at Halifax, in June, delegates will consider a recommendation of the executive committee that a program of accreditation of nursing schools be undertaken. This recommendation arises from the pilot project on accreditation of nursing schools which the Canadian Nurses' Association undertook during the past two years, when 25 representative nursing schools throughout Canada were surveyed on a voluntary basis. As no standards applicable to the Canadian scene were available at the time, standards of the American League of Nursing were used in the pilot study.

Since the announcement of the Canadian Nurses' Association in February that the recommendation would be to proceed with an accreditation program, considerable concern has been expressed by hospital associations, particularly some of our western members. The belief of these members is that if there is to be a program of accreditation of hospital schools of nursing, it should be undertaken by more than one organization. This is in keeping with the resolution passed unanimously at the 15th biennial meeting of the Canadian Hospital Association in Montreal in May of 1959, which stated:

WHEREAS the Canadian Nurses' Association is at present conducting a pilot project for the evaluation of schools of nursing in Canada,

AND WHEREAS a program for the accreditation of schools of nursing in Canada may be deemed desirable as a result of the findings of the pilot study,

THEREFORE BE IT RESOLVED that if such a program for the accreditation of schools of nursing is to be inaugurated that it be under the control of a joint committee of the groups primarily concerned with the education of nurses and that the Canadian Hospital Association should be a member of such a joint committee.

Discussions with the officers of the Canadian Nurses' Association would indicate that, if the program were approved by the delegates of that association in June of this year, some time would necessarily elapse before standards could be developed to meet the Canadian situation and before the program could become operative. The thinking of the hospital people is that now is the time to decide what organizations should conduct the program.

Such a program holds much interest for hospitals generally because the bulk of nursing schools are located in hospitals. Our understanding of any accreditation program is that it is an educational means of improving standards. Such a program is voluntary and in order to be successful must have wide support. We cannot see how the Canadian Nurses' Association program of accreditation can be successful without active support of trustees, administrators, and medical staffs of those hospitals which conduct schools of nursing. It is apparent that some hospitals, at least, are not prepared to endorse the program until they are assured that the program rests on a representative basis.

Trusteeship is a Public Trust

W. I. Taylor, M.D.,
Toronto, Ont.

It is immediately apparent that trusteeship is a legal responsibility because, by the British North America Act, legal authority from the Crown extends from the Governor General in Council, through the Lieutenant Governor of the province and the department concerned, to the governing body of the hospital. By the firmness of this legal succession, approved by-laws and regulations agreed to by the board have the effect of law for government of the hospital as an institution. But to say that trustee responsibility is one for enforcement of hospital law and regulations does not completely answer the question because the assumption of responsibility can be judged by other than legal criteria. A hospital may be operating within the law but you may have heard people say of it "I wouldn't send my dog there for treatment." Here is a statement which affirms that a hospital should be operated not only within the law but by decent standards of human conduct. It affirms really that human conduct comes into question; and since it does, responsibility for hospital operation is moral as well as legal.

Our English word, responsibility, comes from the Latin word *respondo* — to answer; so to be responsible is to be answerable or accountable. The word *respondo* comes from two words, *re* — again, and *sponsum* — a formal promise. It is because the promise is a formal one that compliance becomes a legal requirement. Related Latin words are *sponsio* — a bond, and *sponsus* — a bridegroom. A bond is a uniting or restraining force, something by which one is bound. A bridegroom is one who is bound by a formal promise. To be responsible, then, is to be answerable or accountable because one is bound by a recognizable legal and moral obligation consequent upon an inferred solemn and formal promise. A hospital trustee is bound to the hospital, and so being a trustee of a hospital is very much like being married to it.

The trustee's responsibility is an obligation binding upon him both as to legal liability and moral accountability. It is an obligation which is ever present for the duration of his trusteeship. It is not suspended or attenuated during the interval between board meetings. The responsibility binds him to others, because a trustee is someone who holds something in trust for another. Those who give a trustee something to hold in trust give evidence of their firm belief in his integrity and strength. They express their confidence that he can and will exert guardianship over the thing entrusted to him with uprightness and power so that it will be used for the purpose intended with no diminution of value and with a reasonable interest return.

Hospital trusteeship is a public trust. That is, it is a trust with social rights and privileges vested in the trustees. The trustees' legal responsibility is to guard the principal of the trust. Their moral responsibility is to guard its principles. Trusteeship over the investment and use of the principal may be said to be largely a legal responsibility — guardianship of the principles is largely moral, but the two are inseparably bound. No clear line of demarcation can be drawn between a trustee's legal and his moral responsibility, even though fulfilling the obligations of one may sometimes bring him face to face with special challenges of the other. This apparent conflict, which sometimes seems to exist between what seems legally required and what seems morally right, between what is economically possible and ideally desirable, creates one of the most difficult problems of the hospital trustee.

The Author

Trustees are constantly required to make value judgments on tangible problems which have such an overlay of intangibles that supernatural wisdom seems to be required of them. For this reason the selection of trustees is very important to a hospital. Hospital trustees should be exceptionally well informed and broadly educated, mature men and women with intelligence, experience and integrity of purpose, enabling them to see a hospital problem in its proper setting and enabling them to judge with discernment, prudence and charity.

Concerning the nature of hospital trustee responsibility, then, we can say that it is one which makes the trustee legally liable and morally accountable to hold in trust the principal and principles committed to his care.

Let us look at certain specific areas of trustee responsibility. In so doing, I shall talk more directly to those who are hospital trustees and refer frequently to the *Standards for Accreditation of Canadadian Hospitals*. The Basic Principles of the *Standards* say that the trustees are legally and morally responsible to the patient, the community and the sponsoring organization to ensure the safety of the patient and promote his welfare. They should do this by provision of an adequate physical plant, good administration, facilities for cer-

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The author is executive director of the Canadian Council on Hospital Accreditation. From an address presented at the Maritime Hospital Association, Finance Institute, 1959.

tain essential services and proper medical and nursing staffs.

Hospital Operation

The trustees' first area of responsibility is the operation of the the hospital as a hospital. "The governing body is responsible for the conduct of the hospital as an institution". Somehow there is a widespread misconception that since the advent of government sponsored hospital insurance, the government is now responsible for running community hospitals. Let us dispense with this false idea. The government is not responsible for providing a hospital but only for providing hospitalization. The government is not responsible for providing administration, nor for providing hospital personnel or paying them. The government is not responsible for medical or nursing staff. The board is responsible for all these activities. We hear a good deal these days about local hospital autonomy. Perhaps the principle would be more meaningful is we stated it simply as it is in the *Standards*—"the board is responsible".

The expressed intent of government plans is to pay for hospitalization, not to operate hospitals. It follows, of course, that to some degree "he who pays the piper calls the tune". Hospitals will inevitably be affected because planning and policies will be influenced by availability or non-availability of money. However, this is nothing new. They have always had this problem and I submit to you that hospitals which are well run according to law and good principles of organization and management will suffer much less from apparent government intervention because of less marked change in their policies or practices. Government has every right to require justification of its expenditures. Indeed, as taxpayers, we must affirm that they would be guilty of misgovernment if they did not guard the public purse and assure that monies allocated for hospitalization were wisely spent in accordance with the provisions of the various provincial Acts and Regulations.

There might be apparent conflict of interests. If trustees look upon legitimate government inquiry concerning costs as intrusion into management and if they passively abdicate their powers of control, government will have no choice but to step in to exercise control. You cannot operate hospitals or dispense public monies without proper controls. The right of payment for hospitalization is vested in government. The right of hospital control is vested in the board. It is not only trustees' right, it is their duty and responsibility to determine hospital policy and direct hospital management. If trustees fail to fulfil their legal and moral responsibilities to exert controls, government in defence of the public interest must do so. Let there be no doubt who controls the hospitals. The future of our voluntary hospital system may well be in the hands of hospital trustees.

Type of Hospital

The governing body is responsible to the community and the sponsoring organization for the kind of hospital provided. The misconception that building and equipping more general hospitals is the answer to getting more and better patient care is not only costing the people of Canada a lot of money for construction and equipment but in some cases it is militating against patients getting the kind of care they need. A community can finance only a certain amount of construction in any given period. Our preoccupation with building and expending general hospitals has resulted in too few beds being built and equipped for chronic and convalescent care. There is hardly a general hospital in the country which does not have chronically ill and convalescent patients occupying beds that are not suited to their treatment at a cost at least twice what it would be if these patients could be looked after in hospitals built, equipped and staffed to provide appropriate care. Chronically ill patients lie in beds in general hospitals because there is no place for them to go. When, as fortuitously happens in some areas, beds for the chronically ill can be opened for them and their transfers arranged, many of them are soon out of bed and on the way to self help and self respect.

There is another aspect of this which needs much more attention in the future than it has had in the past. That is the apparent competition among hospitals or among communities. One hospital sets up a new service or gets a piece of expensive equipment and so another hospital, not to be outdone, does the same. Perhaps having the service or equipment in one of the hospitals would be adequate to meet the community need. New services need people to operate them. Capital costs are met but personnel costs go on. And perhaps for lack of volume, the skills of those doing the work may never meet the standard of perfection they should. Operating costs are not a direct concern of the accreditation program but they are a concern to trustees. I mention the type of services here because of the effect it can have upon the quality of patient care in your hospital. The accreditation program is concerned with quality and adequacy of facilities for patient care. When adequate services are available in a community, why duplicate them unless long term planning indicates their future necessity? More consultive and co-operative effort among community hospitals seems indicated.

There is still another aspect of the question of a hospital suitable to community need that I must mention and that is having one suitable to the available resources of professional and technical staff. There are hospitals equipped and maintained to do major procedures in some communities where there are no medical staff and technical help trained to do major procedures and little likelihood of getting them. This can only encourage patients to put pressure on the local physicians to do things they have not had training to do, so the patient can have the procedure done "at home". Human nature being what it is, the doctor will do the best he can but that best may not be as good as if the procedure were done 20 or 200 miles away by people with adequate training. It is no use to argue that 25 years ago most of the major work was done by men who had little or no training by modern standards. Forty years ago much of it was done on the kitchen table, but kitchen table surgery does not meet modern standards. I am not saying that men who learned to do things the hard way should no longer be permitted to do them if they are doing them competently. I am saying that people are more important than things, that trained skills are more valuable than technical tools and that times have changed and risk inevitable 25 years ago may be unforgivable today.

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Accreditation of *smaller* hospitals

A. L. Swanson,
M.D., F.A.C.H.A.
Saskatoon, Sask.

THE statement is often made: "The smaller the hospital, the harder it is for the hospital to gain accredited status". This may be the case in some instances. It is the writer's personal belief that it is often easier for a small hospital to become accredited, *provided everyone works together.*

The cornerstone of successful hospital operation is co-operation — co-operation between the community and the hospital and, especially, co-operation within the hospital itself. If there is good teamwork in the hospital, particularly between the board, administration and the medical staff, it should be easier to secure accreditation in a small hospital than in a large institution. The difficulty in a small hospital is that one strong individual or a small but vocal group in opposition may be a serious obstacle to good hospital operation and the achievement of accreditation.

Opposition to accreditation is not usually direct. It is most often voiced as an excuse. Those who oppose it are something like many people who do not attend church regularly. They don't suggest that churches should be abolished. Indeed, they will maintain stoutly that the church is a fine and wonderful institution. But they are too busy, or too tired to attend; or the church is too small or is poorly heated and the acoustics are bad. Small wonder that the church may have a struggle to keep going in order to be available when these poor supporters need to be married, have their children baptized or have themselves buried!

Excuses for lack of accreditation are numerous, but might be grouped under three general headings:—

1. *The Apathetic Excuse* — This approach is characterized by lack of interest, lack of information and such questions as — What is this Accreditation anyway? What's in it for us? If we were accredited, what difference would it make? It would make for a better hospital.

2. *The Antagonistic Excuse* — Some examples of this approach might be listed as follows — We don't need accreditation here. We run a good hospital. Nobody needs to tell us how to run our hospital. Our doctors are licensed to practise medicine and surgery; they don't need anyone telling them how to practise or when they should operate.

All leading medical and hospital organizations in Canada and the United States say otherwise.

3. *The Hopeless Excuse* — This is the most common type of excuse and is typified by such statements as — We're too small. We can't afford a pathologist or a radiologist. We haven't even got a medical record clerk. Our building is overcrowded. We're so busy now that we wouldn't have time to meet accreditation standards if we could.

If you can't offer your people at least minimal standards for good care, should you offer them something inferior?

The answer to most objections or excuses is found in understanding what accreditation is and what it is not.

1. Accreditation is a voluntary movement supported by every major hospital and medical organization in this country. All funds for the operation of the program come from the dues paid by members. There is no political influence. Accreditation does not represent the wishes or ideas of a few crackpots, but has the support of all responsible, informed groups.

2. Accreditation is a teaching, helping program. It is not a police action. It is designed to help all hospitals of 25 beds or more meet minimal standards for good patient-care. It is not designed to grade hospitals in any order of excellence beyond minimal good standards. However, it is noteworthy that many hospitals, including some as small as 25 beds, far exceed the standards and provide much more than the acceptable minimum. Accreditation makes no effort to penalize or underrate hospitals that do not meet standards. It does do all in its power to help and to encourage these hospitals to meet standards.

3. Accreditation does assess hospital and medical staff organization, physical facilities and equipment and all records having to do with patient care. The surveyor evaluates the care that is being received by patients. It does not attempt to judge the calibre of medical practice but rather the potential for good practice.

4. Accreditation does use various yardsticks or standards for all hospitals but the surveyor's interpretation is not necessarily rigid. If the hospital is a fire trap, there is no room for compromise. On the other hand, the need for a pathologist may depend on the size of the hospital. For example, small hospitals meet the pathology standard if they have part-time service from a visiting pathologist or if they send tissues and complicated laboratory work to a pathologist in another centre.

5. Accreditation does employ the same standards for all hospitals. As mentioned above, there is considerable allowance for intelligent interpretation of many of the standards, particularly in smaller

The Author

Mr. Swanson is the Executive Director of the University Hospital, Saskatoon, Sask.

From an address presented to the 16th Annual Convention of the Associated Hospitals of Alberta, October 28, 1959.

Table 1

Accredited Public General Hospitals in Alberta by bed size groups December, 1958*

Bed size group	Hospitals	Accredited	Percentage
25-49	37	1	2.7
50-99	22	5	22.7
100 and over	11	11	100.0

*The inclusion of mental, T.B. and government hospitals, most of which are accredited, will increase the total number of accredited hospitals and the total percentage.

Table 2

Comparison of Accredited Public General Hospitals in Certain Provinces and in Canada as a whole, December, 1958*

Province	Hospitals over 25 beds	Accredited	Percentage
B.C.	71	19	26
Alberta	70	17	24
Saskatchewan	54	17	31
Nova Scotia	31	20	64.5
Canada	575	234	40.7

*The inclusion of mental, T.B. and government hospitals, most of which are accredited, will increase the total number of accredited hospitals and the total percentage.

Table 3

Comparison of Accredited Public General Hospitals by bed size groups in Alberta and Nova Scotia, December, 1958*

Alberta

Bed size group	Hospitals	Accredited	Percentage
25-49	37	1	2.7
50-99	22	5	22.7
100 and over	11	11	100.0
Total	70	17	24.4

Nova Scotia

Bed size group	Hospitals	Accredited	Percentage
25-49	12	4	33.3
50-99	7	5	71.4
100 and over	12	11	91.6
Total	31	20	64.5

*The inclusion of mental, T.B. and government hospitals, most of which are accredited, will increase the total number of accredited hospitals and the total percentage.

hospitals. Likewise, small hospitals have fewer standards to meet than do larger institutions. All hospitals, large or small, must meet standards in ten basic areas. In small hospitals these may be all the departments that are maintained and, therefore, all that are surveyed. Large hospitals must meet standards in as many as 22 different departments. This is certainly a circumstance that makes it easier for a small hospital.

6. Accreditation does seek to elevate patient-care standards on a continuing basis. It is not a static program. Standards are continuously being upgraded to keep pace with scientific, economic and social advance. Much that was good in hospitals ten years ago will not suffice today. The only hospital that does not need accreditation is the perfect hospital. We have yet to find such an example.

7. Accreditation does build good feeling and morale for the medical staff in the hospital. The fears that frank and full discussion of interesting patient conditions at medical staff meetings would be embarrassing or would promote medical staff difficulties, have proven groundless. On several occasions when visiting hospitals where medical unrest existed prior to accreditation, doctors have made a special point of mentioning to the writer how much better their relations are now. Once the physicians succeed in taking down the bars between themselves and enjoy free and frank discussion of medical problems, their work becomes more pleasant and fruitful. When they are able to work together as an organized team, their knowledge grows and their skill increases.

The foregoing should serve to answer most excuses. Still we are faced with statistics which indicate that only a minority of eligible hospitals have sought accreditation. We know that most hospitals that try for accreditation get it eventually, if not on the first survey. We know that, once accredited, hospitals seldom permit themselves to lose this status. We know that when an accredited hospital does lose its position, tremendous efforts are made to regain recognition, often successfully within a few months or a year. Evidently accredited hospitals feel they have something of great value in accreditation. Yet relatively few enjoy the experience.

In Alberta there are 70 public general hospitals or 25 beds or more of which only 17, or 24 per cent, are accredited. The picture is similar in other provinces. Saskatchewan, with 54 eligible public general hospitals, has 17, or 31 per cent, accredited. British Columbia figures are 19 out of 71, or 26 per cent. There is reason to believe that each of these provinces has added two or three to its accredited list since these figures were published in December, 1958. The figures given do not include mental, T.B. and government hospitals, most of which are accredited. Nonetheless, the number of accredited public general hospitals is growing much too slowly.

The figures are still more interesting when broken down into bed size groups. For Alberta they are shown in *Table 1.*

There is no doubt that larger hospitals are much more often accredited. This fact is apparent in all provinces and in Canada as a whole. *Table 2* shows a comparison of accredited public general hospitals in certain provinces and in Canada as a whole.

It will be noted at once that the record in the three western provinces is not as good as for Canada as a whole and that the small province of Nova Scotia outstrips the west by a wide margin. While this table may be damaging to the pride of westerners, it does illustrate that accreditation can be attained by a majority of hospitals. It also shows that even in Nova Scotia there is room for improvement.

Table 3 illustrates a still more pertinent fact. Small and intermediate size hospitals can, and do, gain accreditation!

It may be seen that in Nova Scotia the percentage of accredited small hospitals exceeds the total percentage in Alberta of small and large hospitals. This also applies to B.C. and Saskatchewan. Surely we

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A purchasing agent looks at

disposables

Ivor H. Hunt,
Toronto, Ont.

IN consideration of the controversial topic of disposable hospital supplies versus re-usables it is desirable to approach the subject with an open and analytical mind. The problems involved in a plan to incorporate disposable supplies into the general hospital function are complex and in many cases singularly individual to a particular hospital's operation. The adoption for routine use of to-day's disposables can have a direct bearing on the hospital per diem rate and the general over-all cost picture. Hospital administrators and officials are aware of the many advantages offered by disposables in their application to patient care, and their contribution to the reduction of labour costs in the hospital. However, they are also aware of the operating problems that are involved in a plan for conversion to some of to-day's disposables and the inflated cost which could result from the adoption of many. Before a hospital decides whether to use a disposable or continue to use a re-usable item, as many personnel as possible should be consulted.

In order to arrive at a solution it is necessary to conduct a complex and exhaustive analysis of all factors involved. Proper evaluation of a product must include an analysis of the procedures and techniques involved in its use. This requires a process of continuous education for the administrator or the purchasing agent, as the case may be, together with the personnel who perform the end function. Not only does one have to know the cost price of the article, but one must also know how many man hours or man minutes will be consumed, when the article is used in surgery, the central supply room, the laboratory, the food service department, the laundry or anywhere else in the hospital.

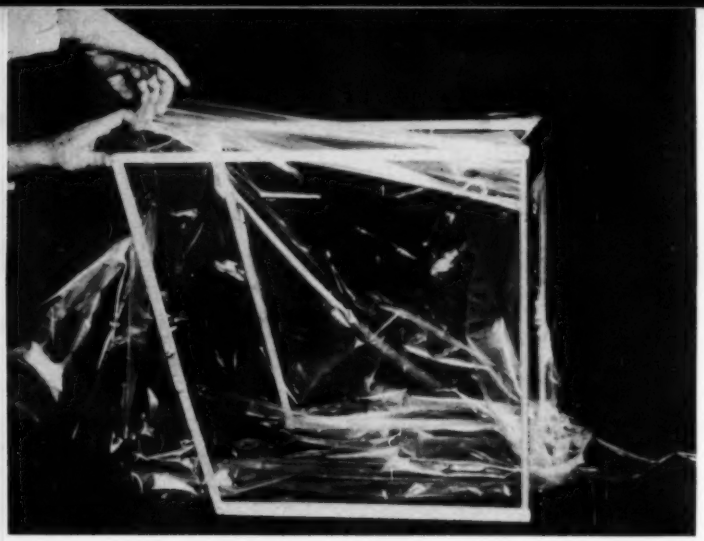
The elimination of any one individual from the pay roll may well offset higher purchasing cost. Therefore, proper evaluation of a product must include a complete analysis of all factors involved in its use. Such evaluations take time but it is certainly necessary that we find the most suitable answers for our particular institution.

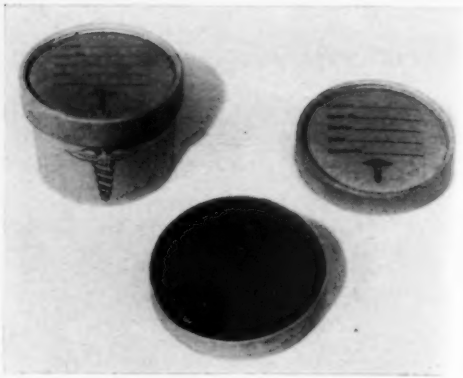
The author is purchasing agent at Toronto East General and Orthopaedic Hospital.

What may be good for one hospital, may not work in another. Types of services, equipment and personnel, all have a bearing or a part in a hospital's decision to accept or reject a particular type of supply. For example, disposable syringes might be the correct product for a large metropolitan hospital having a large volume of turn-over on re-usables and a resulting high labour cost; but, on the other hand, they may be of no value at all in another hospital within a distance of twenty-five miles.

The problem is one faced by all hospital administrators. Can we obtain a better product which will demand less time? Is it then possible to eliminate duplication of labour and hold down the ever increasing number of employees? Administrators are all aware of what department heads want more of each year—more help. They are faced on the one hand by the necessity of holding down pay roll expense and on the other by retaining a realistic operating cost picture.

Disposables may, in part, make a definite contribution to the labour situation, not with the objective of reducing staff, but with a view to eliminating the necessity of additional staff. Anyone who endeavours to forecast what is going to happen in the field of disposable hospital supplies during the next ten years is certainly risking any reputation he may have as a prophet. At no time during the 25 years I have been associated with hospitals, have there been a greater number of unpredictable factors to be considered. However, we shall make some calculated guesses, based on the information we have and on experience with certain disposable items which have been introduced and accepted for routine hospital use during the years. Disposables are not new. The idea has been with us for some years. Many of the applications are new, however, the logical result of newer materials and more efficient production methods. Basically the whole idea of disposables is aimed at improved patient care—in the face of rising costs, a reduction of direct labour





The disposable specimen cup seen above has a new improved lid with a jet black lining similar to black glass for the easy observation of sputum pus cells. It can also be used for other purposes.

costs (generally considered about 70 per cent of hospital expense), and a better utilization of staff abilities. Many hospitals are transferring constantly rising labour costs to controllable supply cost through the use of expendables. Both ideas are fundamentally desirable and worthy of every consideration. Those who have been associated with the hospital field for some years will recall many of to-day's accepted disposables which were practically unheard of during the middle thirties. They will recall also that much the same problems existed during those times as we are facing today—expense and labour problems. To hospital people, the most important factor in the final analysis is a product's application to patient care.

Through the years past and the years to come, the success or failure of these to win acceptance by hospitals has been and will be predicated on their evaluation as a more acceptable and efficient means to improve patient care. True there will always be the cost factor to be considered but final evaluation will be dependent on this single factor—*patient care*. During the past ten to fifteen years, we have seen many disposable items introduced and eventually accepted for routine hospital use. Many of to-day's commonplace items received much the same evaluation before being accepted. Hospitals have steadily increased their use of expendable products, because expendables often offer better and safer patient care and more efficiency in use at lower costs. This trend has progressed through disposable dressings, disposable blood administration sets and parenteral solution administration sets that were designed and introduced to eliminate the possibility of reactions that often resulted from the presence of pyrogenic materials remaining in their re-usable counterparts. Flexible paper straws are used to replace the original bent glass variety that presented such a cleaning problem. Even the disposable wooden tongue depressors and cotton tipped applicators have contributed as disposables to replace the old metal instruments of former days. Disposable underpads to replace the launderable and often expensive types have also met with wide acceptance. Varieties of towels, catheters, duodenal tubes, wash cloths, masks and many others, have had a good measure of acceptance and all have contributed to better patient care. Some of the more recently introduced items that are being widely accepted in many hospitals throughout the country are: paper sterile wraps, to replace the traditional textile autoclave wraps and paper tray service for contagious or isolation cases.

In the main, many of the disposables make a definite contribution to hospital care even though the process of evaluation and acceptance may be slow.

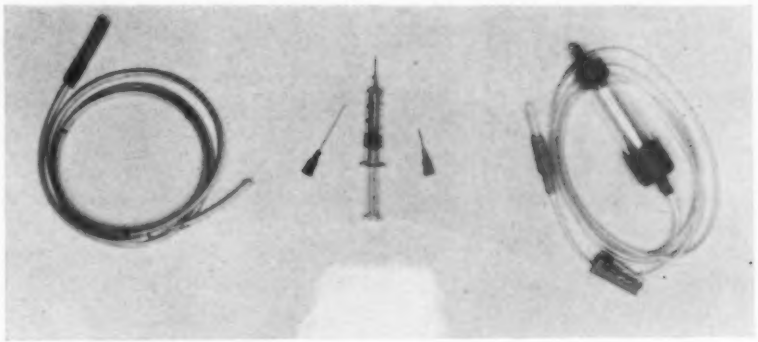
To-day, the list of disposable items presented to the hospital purchasing department is formidable indeed; and covers items designed for every function and service from clothing to routine laboratory supplies. The manufacturers do not appear to have overlooked a single possibility and in our opinion such research should be applauded. The latest item which has come to our attention is a type of disposable bed sheet which can be used routinely if laundry costs are high or can be used as an emergency item to supplement linen supplies in the event of shortage due to breakdown of equipment, labour problems, or other factors which may contribute to a shortage.

Among the most recent disposables being offered, there are many which appear to have a great deal of merit and which, in our opinion, will make a definite contribution to patient care. These include such items as disposable paediatric urine collectors and the various disposable colostomy and ileostomy accessories. We believe it is safe to assume that these will gain wide acceptance in a short time because of their obvious advantages and direct application to the patient's well-being. The same can be said for such items as pre-sterilized levine tubes, feeding tubes and oxygen tent canopies all of which have definite advantages over their re-usable counterparts. Probably one of the most dramatic and controversial innovations has been the introduction of disposable pre-sterilized syringes and needles; and although there would appear to be no doubt that these will eventually make their contribution to medical science and to hospital care, they present a problem which must receive complete and careful evaluation. A calculation based on an approximate number of injections administered per bed per month in the average general hospital will show a cost figure of astronomic proportions. Initial cost alone does not necessarily indicate true expense and, on the other hand, it is quite possible that an accurate and complete analysis of all cost factors involving the processing of re-usables might result in a cost-of-processing figure higher than the cost of the disposable. To a large extent the cost is dependent on methods and equipment, location and personnel. In the constant flow of disposable items being offered to-day there are many which

may not receive the attention they merit. One item which comes to mind, and which can hardly be classified as new, is the disposable oxygen tent canopy. In the constant efforts of nursing personnel and administrators to prevent and guard against cross infection, it would seem to us that this item could contribute a very important part. In addition to eliminating the danger of cross infection from that source, a disposable in this case eliminates the time-consuming labour factor involved in the washing and processing of canopies after use. In many cases, the procedure for washing and carbolizing a re-usable type canopy may expend valuable hours of nursing service time, and in many cases it is questionable whether or not the danger is completely removed.

No one can say that disposables are, or are not, better than re-usables. First you must evaluate your institution and carry out a process of evaluation of the various items that may be presented for consideration and, finally, prove your statement statistically. If you arrive at an answer and if your analysis indicates that it is an objective and accurate one, then, whatever that answer may be, it is the correct one for your hospital. In the final analysis, the point we are stressing in this discourse, is the necessity for research and evaluation by cost study analysis. Supplies, procedures, techniques and operations, all are related irrevocably and any evaluation must include all factors related to each.

At our hospital we endeavour to keep informed on the various disposables that are constantly being offered and to evaluate their advantages and disadvantages, as they apply both to patient care and to operating costs. We have evaluated and tested many items ranging from bed gowns to microscopic slides. We have looked into the possibilities of disposable presterilized catheters and disposable drainage collection bags, but we have decided against disposable syringes for the time being. On the other hand, the current low cost of hypodermic needles makes it impractical to re-sharpen at a cost which is fractionally lower than new needles. The same situation applies to scalpel blades which were formerly re-sharpened and which are now considered as a disposable. Competition and more efficient production methods often relegate a former re-usable item to the status of a disposable when costs are reduced to the point that re-use becomes impractical. Some of the newer disposables are most ingenious and the possibilities are intriguing, to say the least. At the present time we have, for testing in the near future, a disposable operating pack. This is a completely prefabricated and pre-sterilized disposable paper operating pack containing all of the variations used for general laparotomy, lithotomy and other specialized positions and surgery. These units are being offered at a cost of $3.50 to $4.00 per operation, and the possibility of reducing labour costs in the laundry, the central supply room, and the operating rooms is something which titillates the imagination. We have yet to examine the possibilities of disposable surgeon's gloves, but have evaluated the disposable examining glove. These have been accepted for use in certain services when a review has indicated a practical and economical application. We are also testing in our surgeries a type of disposable plastic operating drape material. It consists of a soft, pliant plastic which is adhered directly to the operative field with an adherant. It clings to the patient's skin and will not come loose during the procedure to permit accidental contamination of the operative field. It conforms to irregular anatomical sites and the incision is made right through the plastic skin drape so that protection is complete to the wound edges. This method replaces use of skin towels and clips and may turn out to be a great advance in aseptic surgery.



Disposable administration sets.

In many hospitals the problem of storage space is often acute and the addition of a large volume of disposable items, in order to assure a continuity of supply, is a factor to consider. Those hospitals situated long distances from the source of supply would find it necessary to anticipate and store their requirements for definite periods. On the other hand, the large volume of some disposable items that would be required in the larger hospitals would in itself present a storage problem of no small dimension.

Any plan to adopt disposables should be considered from every aspect. We know that abuses can exist regardless of controls and constant scrutiny; and where the disposable supply is concerned these are often considered in the light of their individual costs and the possibility exists of misuse resulting in waste.

Another consideration is the existence in most hospitals of expensive capital equipment for the processing of re-usables. It would be sheer speculation to say whether or not the over-all disposable picture could present a saving large enough to justify the obsolescence of such equipment, but we think not.

In some hospitals, many of which may not be adequately equipped with incineration facilities, the final disposition of a large volume of disposable material could easily present a problem. Thus it is evident that in any large scale conversion to disposable supplies all factors must be evaluated as they apply to your institution. These could be listed briefly as follows: (a) value to patient care; (b) cost of disposables; (c) cost analysis of re-usables; (d) evaluation of capital equipment; (e) storage facilities; and (f) disposal facilities.

In retrospect, we have seen many disposables accepted for routine use and we reiterate that any prophesies regarding the adoption of many of to-day's disposables

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EMPLOYEE-MANAGEMENT COUNCIL

a boon to Winnipeg General

T. I. Jongerius
Winnipeg, Man.

THE key to an executive's success lies in his management of employees. This fact has become increasingly important and apparent during the past twenty to thirty years; for automation and specialization have weakened employee satisfaction and pride of individual accomplishment. With the thought in mind that a satisfied worker is a good worker, management has attempted to increase employee satisfaction by improving working conditions, pay, and opportunity for advancement. All this has still not been enough. It has not replaced what automation and specialization have taken away.

Why strive for employee satisfaction?

A satisfied employee is a good worker. His productivity increases. His accident ratio decreases. He gets along well with his fellow employees and his superiors. He is proud of his job and the place where he works. In short, he is the ideal type of employee every hospital executive wants on his pay roll.

At the Winnipeg General Hospital a good part of the answer to the problem of employee satisfaction has been found in participative management. An employee-management advisory council, better known throughout the hospital as the E.M.A.C., gives every one a chance to participate in the broader aspects of the hospital's activities. This increases interest, identity with the hospital, and most important, job satisfaction.

Here are a number of points which are covered by our council system to increase employee satisfaction and thereby increase the value of every man and woman to the hospital organization.

Freedom to offer suggestions and criticisms is of the utmost importance in building greater job satisfaction. The worker who feels that his boss never considers his ideas soon loses enthusiasm for his job. The employee who knows he can always offer suggestions or even criticize has much more faith and confidence in the hospital and his job.

Not only is job satisfaction increased but experience has shown that where freedom to criticize and suggest exists many excellent ideas and suggestions come up from the employee ranks. Nobody —not even the top man—can know all there is to know about everything. By-passing the people who work for you is wasting brain power.

Understanding of hospital problems should go far beyond the management circle. The employee who has a full understanding of the hospital problems will be a much more satisfied individual. An employee of this sort performs his job much better as he sees how it fits into the over-all function of the hospital.

An employee who fully understands the problems of his hospital and who is proud of the hospital for which he works can always meet questions directed at him by outsiders and thus plays an important rôle in the field of public relations.

As you can see the aim of our system is to make the employee feel that he or she is not just another faceless cog in the hospital machine. Each employee must be made to feel that he as an individual is important to the hospital management.

What is the E.M.A.C.?

The employee-management advisory council is precisely what its name implies—a council composed of representatives of the employees and the management to increase production and service, and to improve efficiency through greater co-operation between both groups. It is a two-way communication channel for the exchange of ideas and information on mutual problems.

The E.M.A.C. is not designed to relieve management of any of its responsibilities, nor is it a device to be used by either management or labour for their own ends.

The preamble to the constitution of the Winnipeg General Hospital employee - management advisory council best expresses the basic function of the organization. It reads as follows: "Recognizing the community of interest in providing a high quality of patient care through the efficient and economical operation of the hospital and believing that good patient care and hospital relations rest upon satisfactory co-operation among the hospital staff as a whole, the management and the employees agree to work together in the establishment and operation of an Employee-Management Advisory Council."

How the Council system works

The council functions are of an advisory, not of an executive nature, that is, the council makes recommendations to management and thus does not perform the functions of management. In this way it helps management reach decisions with the added knowledge the representatives provide.

The council consists of a chairman, a secretary, fourteen elected representatives, six appointed representatives, and one ex-officio member. The chairman is elected by the council and serves for a period of time as agreed upon by council members. It is the chairman's duty to see that the proper spirit and attitude prevail at the council meetings. The secretary is appointed by the chairman and the council, and is not a member of council. The secretary's duties consist of taking and distributing the minutes of the meetings, and preparing agenda as received from council members.

The departmental representatives are elected by the employees of various departments throughout the hospital. These members receive suggestions and ideas from the employees in their department and report to the council. They decide what suggestions and ideas are in order and should be passed on to the management.

The management appoints six representatives who perform the same function as the elected re-

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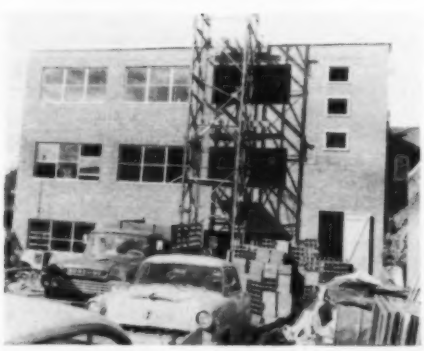
Mr. Jongerius is personnel assistant at the Winnipeg General Hospital, Winnipeg, Man.



C. H. A. HEADQUARTERS

. . . *before and after*

THE new headquarters of the Canadian Hospital Association (25 Imperial Street, Toronto 7) has been occupied since January of this year and the building will be formally opened during the meeting of the C.H.A. Assembly next week. It is a compact modern structure, 47 feet wide by 70 feet deep, with the outer walls finished in red brick. Each of the three floors contains some 3000 square feet of space and the foundation can support a fourth floor at some future date. Air conditioning ducts, as well as shafts for an elevator and a dumb-waiter have been installed for use later. There are movable steel and glass partitions, the ceiling is of acoustic tile banded by semi-recessed, continuous strip fluorescent lighting.

The ground floor houses the education division of the association; the library, with 2,000 lineal feet of steel shelving; print shop and stores area; and the oil-fired, fully automatic heating unit.

On the next floor, the office of the executive director and a reception area, by rolling back the curtain doors, can be converted into a board room to accommodate 20 people. The secretarial staff occupies the central section of this floor; and the southern portion is occupied by the advertising and editorial staffs of *Canadian Hospital*. For the present the third floor is to be rented.

The above pictures show the old building in which the association occupied the third floor and a basement suite, a packing up scene and structural development of the present building.

CHANGING CONCEPTS

in medical and hospital care

L. F. Detwiller, M.A., M.H.A.
Victoria, B.C.

LITTLE more than 100 years ago, there was not the demand for health services which exists to-day because there was not so much benefit derived from them. Now, because of the tremendous strides that have been made in medicine and allied fields, we are inclined to feel that almost anything is possible by way of prevention, diagnosis, treatment, and rehabilitation — if we but set our minds and resources to the problem. With the large scope of benefits that are available through medical care, there is little wonder that such a tremendous demand in these services has developed through recent years. However, the problem now is that of determining the quantity and quality of medical care which we should receive and what is going to be the best way of providing it for the people.

Considering the number of groups, both professional and otherwise, which are associated with medical care, it is not surprising to find strong differences of opinion on this subject. To integrate and co-ordinate these differences represents a real challenge for the future.

One of the major problems is how to meet the increasing demand of the public for a greater volume and higher standard of medical care. One of the reasons for the increasing awareness of the public about medical affairs is the popularity enjoyed by articles on medical topics which appear with increasing frequency in popular periodicals and journals. Many magazines have sections devoted specifically to medical care. The outlook on health is rapidly changing, not only in our demands as consumers for health services and products, but also in our basic philosophies in the health field. There appears to be a trend towards considering health as something which we should enjoy as a basic right as a citizen rather than as a privilege and service for which we are responsible as individuals.

This observation would certainly seem to apply to the hospital field in Canada, where we now have a federal-provincial hospital plan, but does not apply to the same degree to the services of the doctor. While we do have medical coverage schemes for certain groups in society, which are supported by government funds, most of the medical care which we receive as individuals from our private physician is of the fee-for-service, private practice type rather than that which is provided under a socialized medical plan, such as is in effect in England.

This changing philosophy and increasing demand for medical care is making itself apparent in the United States through somewhat different channels than in Canada. However, it is interesting to note that, in the United States, where the concept of free enterprise and the right of the individual is stressed as the key-note of the economy, the philosophy of health as a "basic human right" is being proposed, not only by American labour groups, but also by several of the recent presidents of the United States. It would be interesting to know if the bases for these statements by the presidents concerned stemmed from their individual philosophies or whether they are making more in recognition of the changing point of view of many of the people.

The Author

The Health Of Its Citizens

In 1944, President Roosevelt stated, "Among basic human rights are adequate medical care and an opportunity to achieve and enjoy good health." In 1954, President Eisenhower stated, "The means of achieving good health should be accessible to all. A person's location, occupation, age, race, creed, or financial status should not bar him from enjoying this access. No nation nor administration can ever afford to be complacent about the health of its citizens."

In Canada, ever since 1919, Canadians have been talking about health insurance through their political parties and their governments. The major parties have each supported health insurance in their platforms, and programs are continually being discussed at the sessions of both federal and provincial legislatures. While various groups have expressed opposition, 1959 saw the introduction of a national hospital program. The Canadian people have placed hospitalization alongside other necessities of life, and look on it as a service which is to be obtained through government assistance.

As far back as May 14, 1948, the Prime Minister of Canada stated, on the occasion of introducing federal health grants: "They are, in effect, a fundamental prerequisite of a nationwide system of health insurance." Reference was made to this statement when the "Hospital Insurance and Diagnostic Services Act" was introduced to the Federal House on March 25, 1957.

It is interesting that the demand for coverage for medical care which, in the United States, is appearing mostly in industrial and commercial fields and is being met for the most part, through volun-

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From a paper presented at the Vancouver Island Hospitals' Regional Council, April 4, 1959. The author is Assistant Deputy Minister of Hospital Insurance, British Columbia.

tary plans is, on the other hand, making itself felt through political channels in Canada. This is understandable since we in Canada are much more prone to accept government in our affairs — something which is, no doubt, a direct result of our association with England. Nevertheless, the same problem exists in both Canada and the United States. One important point on which we appear to differ is the method of financing hospital service. However, while in the United States there is no recognized governmental program which provides medical or hospital care for the population as a whole, nevertheless, it is a fact that in recent years approximately 30 per cent to 35 per cent of all the dollars spent for medical care are received from the various levels of government. This includes the care provided the Armed Forces, governmental groups, and grants at all levels of government towards medical care programs.

Medical Care Expenditure

A similar situation prevails in Canada and, with the introduction of the federal-provincial hospital scheme, this figure is probably higher to-day. This is especially interesting when we compare this percentage of medical care expenditure to that in some of the other countries, such as Norway, which are considered to have national health programs. In Norway, it is estimated that only 20 per cent of the medical care plan costs come from governmental sources, the rest coming from payments by participants, (covering about one-half of the remaining 80 per cent of the cost of the plan) and the balance being paid by employers. While we tend to think that in North America we have had a voluntary system of medical care coverage for the most part, in reality we have had a considerable degree of tax dollar participation.

The percentage of national income spent for medical care in the United States has risen from 3.6 per cent in 1929 to 5½-6 per cent of the national income to-day. The same trend has taken place in Canada. In making comparisons of the medical care costs with the consumer price index in the United States, it is interesting to note that, expressed as a percentage increase from 1936 to the present hospital room rates showed the largest increase; in fact, the largest for any of the services in the consumer price index as calculated by the United States department of labour. On the other hand, professional medical service fees show less increase than hair cuts, shoe repairs, movie admissions, public transportation, laundry, and many other services.

When the expenditures for medical care are analyzed, it is interesting to note that the proportion of the consumer budget going for medical care has been changing. To-day, the hospital's share, which has been steadily rising, is the larger share, and the physician's and dentist's shares have been steadily declining. The practice of medicine is being concentrated more and more in the hospital because of the specialization which has developed in the medical field, necessitating new and more elaborate equipment. The greatest determining factor in the rise of costs is the type of medical practice that is carried on in the hospital itself. Increases in the number of staff, cost of equipment, et cetera, are mainly reflections of the changing pattern of medical care in the institution.

Problems

One of the difficult problems facing hospitals is to explain this tremendous increase in cost for a service, which could almost be classified as an "undesired necessity". Most people are prepared to spend money for food, heat, and clothing, and will even save to provide these items. However, in the past, we have not been prepared to set aside sums to meet the unpredictable expense of illness. On the other hand, when we do require the doctor's or hospital's services, and life is in danger, expense becomes meaningless, and we insist that the best be made available, without any regard to what we may have done to provide the services required.

In hospital service to-day, a rough division between labour and materials is 70 to 75 per cent labour and 25 to 30 per cent for materials. On the other hand, in business and industry, the composition of many products is roughly 40 per cent labour and 60 per cent for materials. This cannot be applied to all items, but is a rough approximation. If there is a 50 per cent increase in the wage level, it has almost doubled the effect on the cost of producing a unit of hospital service as compared to many industrial or commerical products, because the ratio of labour to the finished product in hospital service is almost twice that of the product of business or industry. Automation is much more difficult to achieve in the hospital field as each individual presents a special problem. While a drug may have a beneficial effect on one person for the treatment of a specific illness, another patient may have an allergy to the drug and may require a completely different method of cure. New discoveries often require new types of equipment for diagnosis and treatment. In industry a new piece of equipment may lower the cost of operation by reducing staff through automation. But in the hospital it may well require the employment or training of an entirely new type of technician. This cost is ultimately reflected in higher operating costs for the hospital.

One of the difficult decisions that has to be made in providing medical care services is the standard and scope of the services that will be provided and their degree of availability throughout an area. There is almost no limit to the amount of money that can be spent on medical care, but there is a very real limit as to the proportion of our income that should be used for this purpose. What this limit should be varies with every individual. It is only through collective action on the part of hospital boards and the people through directives given to their representatives that these limits are finally determined. Economic laws of supply and demand are usually allowed to operate with a resulting market price for the sale of automobiles, metals, et cetera, but when human life is concerned, the logic of economic laws is often disregarded and society sets up counteracting demands which upset the usual economic balance. It is because of this emotional viewpoint that the administration of a prepayment plan can become very difficult, especially if government is involved. Individually, we are inclined to disregard cost when personally faced with a medical care problem but collectively we are much apt to consider the financial implications of the problem on a more logical basis. The person who criticizes the total cost of medical care could well be the first one to protest the lack of service in his hospital which was the direct result of a budget reduction. This is especially true if the service is one required by himself or one of his immediate family.

It is this process of determining the balance between medical care

(continued on page 90)

TORONTO WESTERN HOSPITAL

LAST summer the Toronto Western Hospital embarked on a multi-million dollar expansion program which will add four impressive buildings to the hospital — a nurses' residence, an interns' residence, and two large patient care units, the Bathurst and Nassau buildings. The architects for the project are Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside, Toronto, Ont.

Construction began first on the nurses' residence. Like the present Edith Cavell residence to which it is joined, the new unit will be nine storeys high. It will provide facilities for 112 student nurses. This means that 288 students can then be accommodated at the hospital's progressive Atkinson School of Nursing. The residence will also have an excellent library and common room.

The interns, too, will be well looked after. Their new residence will have 60 beds and will replace the present residence (built in 1936) and a number of old houses in and around the hospital grounds which have been used as interns' quarters for some years. The new unit will have five floors and a basement. On each of three floors there will be 16 rooms, a library and a study room; on one there will be 12 rooms and a common room. The ground floor has a recreation room for the interns and a completely new kitchen to serve the entire hospital. The basement will house refrigeration, freezer units and storage facilities. Eventually, the present interns' residence will be renovated and made part of the out-patient department.

The third unit in this expansion program will be known as the Bathurst Building. In the basement of the building will be storage, mechanical departments, and employee locker rooms. Its main floor will comprise the main lobby of the hospital as well as the emergency and admitting departments.

The emergency department will feature covered parking space for ambulances all of which can be serviced quickly. Space will also be provided for other emergency and police vehicles. The department will also contain a resuscitation unit (a self-contained room), an x-ray unit, two operating rooms, four treatment rooms, four examining rooms, four two-bed recovery rooms, a fracture room, a small laboratory and a disaster supplies storage unit. Completely air conditioned, it will be joined to the present emergency department which will be remodelled to provide 16 overnight recovery rooms, two quiet rooms and sleeping accommodation for two members of the medical staff.

The hospital's extensive department of rehabilitation medicine will be housed on the first floor of the Bathurst Building. It will provide accommodation for in-patients and for ambulatory cases. Its equipment will include wax baths, a remedial pool, Hubbard tanks, a gymnasium and an exercise room. Also on this floor, there will be a teaching auditorium to be used by the various hospital departments.

The Nassau Building is the fourth in the program. It will be directly north of the main pavilion and attached to it. The basement and ground floors will contain the hospital's administration offices. There will be beds for patients on the main floor and on the fifth, sixth and seventh floors. The first floor will contain the x-ray department. On the second there will be operating rooms and recovery and

Below

1. Main Entrance
2. Auditorium
3. Out-patient Department
4. Unit No. 3—Bathurst Street Building housings admitting, emergency and physiotherapy departments
5. Ambulance Entrance
6. Unit No. 4—Nassau Building
7. Unit No. 1—Addition to Nurses' Residence
8. Unit No. 2—Interns' Residence

. . toward better patient care

THE nursing staff of The Toronto Western Hospital had a most interesting experience in the form of a three-day workshop held in January of this year. The theme of this workshop was "Toward Better Patient Care".

As with any large and growing institution, and the inevitable changing of personnel, one of the main problems facing the nursing staff of this hospital was the lack of good communication, not only among themselves but with other departments. It was felt that this was bound to have an adverse effect on satisfactory relations with the patient.

As early as spring of 1959 this workshop was under consideration. However, it was not until June that five members of the staff were approached to form the planning committee. Members of this committee were drawn from the departments of nursing service and nursing education. A letter of invitation with a list of suggested reference reading was sent to all those who were expected to attend. In choosing the members of the work groups, an attempt was made to have persons from different departments represented. Personnel from other departments were invited to attend the open sessions and many took advantage of this invitation.

The structure of the workshop consisted of small discussion groups, and at least one main general session daily. The participants numbered approximately 50. This number was made up of the head nurse and clinical instructor group, with administrative supervisors and general staff nurses attending when duties permitted. Carol Adams, the nursing consultant for education and service of the Registered Nurses' Association of Ontario, attended the workshop in the capacity of observer. Her assistance to the planning committee in the day-to-day evaluation of the workshop was much appreciated, for she was able to help correlate the diversified opinions of the groups. All members participating wore street dress; smoking was permitted in the small work groups, and coffee and tea was served morning and afternoon, in an effort to achieve informality. By these means it was hoped to promote freedom to express opinions, state existing problems, and suggest methods of improvement.

The first day the participants registered, and each received monogrammed plastic portfolios containing pertinent literature, bibliographies, and name tags with coloured ribbons attached to differentiate the discussion groups. In all there were seven groups of seven members.

In the first general session the director of nursing, Grace Paterson, outlined the administrative structure of the hospital and nursing department. Following this the associate director of nursing education, Audrey Shiach, presented the philosophy and curriculum of the Atkinson School of Nursing. The information obtained from both these speakers was new to many of the participants, and an excellent review of recent changes for older members of staff. It also proved valuable in clearing up some misunderstandings that may have existed between nursing service and education as to their respective rôles, and provided conversational material for the first group discussion.

As team nursing has been in practice at Toronto Western Hospital since 1950, and problems still exist in this area, it was felt that a review was needed. The general session for the second day was planned, therefore, around this theme. A panel consisting of representatives of the nursing team from supervisor to nursing assistant level was asked to express opinions as to how effective team nursing was in meeting the needs of the patient, and promoting job satisfaction of the team member. This evoked much discussion later, and many helpful suggestions as to how improvements could be made. Another encouraging aspect was the interest aroused in the areas where team nursing is not in effect. Several of the head nurses on private floors are making plans to institute team nursing, as they have been convinced that it improves patient care.

Since one of the objectives of the workshop was to improve interpersonal relationships in order to improve patient care, Dr. Karl Bernhardt, Professor of Psychology at the University of Toronto, was invited to speak on the topic. Dr. Bernhardt pointed out that in a hospital too much emphasis may be placed on efficiency to the detriment of the patients' welfare. He stated that a basic theory on getting along with others is to move outside our egocentric thoughts, which is not automatic. One must have a genuine interest in the individuals as persons and establish a feeling of empathy.

Apart from the general sessions the remainder of the three days was taken up by small group discussions. The leaders of the work groups met with the planning committee prior to the workshop and their rôle as leaders was discussed, demonstrated by use of films and by the provision of reading material. The topic of discussion in the group sessions was left entirely to the members. All members remained in the same group for the entire three days, so that there was continuity of thought and discussion. At the end of each day the group leaders met with the planning committee to discuss the progress in their groups, and to present a summary of their discussions.

At the end of the third day, a final general session was held, where an attempt was made to highlight the common problems of all groups. The director of nursing, the associate director of nursing education, and the medical superintendent were invited to at-

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intensive care units. Besides this, the hospital's cardiovascular unit will be located on this floor along with an orthopaedic operating unit and a neurosurgical operating unit. The third and fourth floors of the building will have additional laboratory facilities. The basal metabolism laboratory will be on the fourth floor, close to a metabolism treatment centre on the fifth floor. The Nassau Building, eight storeys high but designed to take another three floors, will provide bed space for 125 more patients. ■

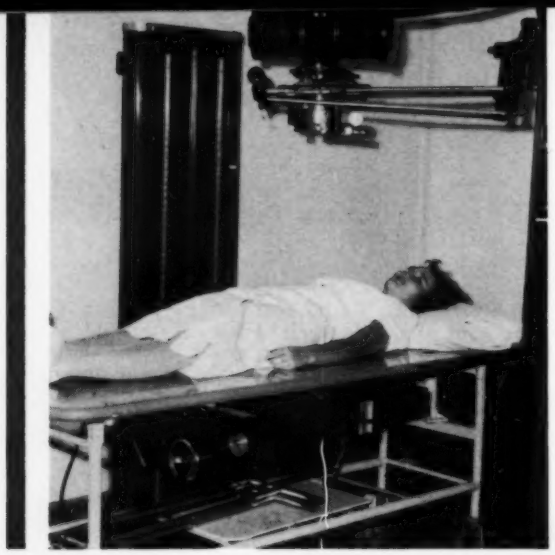


Figure 2

AN IMPROVED EMERGENCY STRETCHER

H. E. Duggan,
M.D., F.A.C.R.
Edmonton, Alberta

FOR some years at the University of Alberta Hospital, Edmonton, Alberta, we have been trying to improve the handling of severely injured patients arriving at the Emergency. We are particularly concerned with those patients who require x-ray examination. In the past these patients have been moved three or four times from one stretcher to another and off and on to the x-ray table. It is our opinion that much of this moving is unnecessary.

With the help of the Department of Surgery we have designed a new stretcher which we think embodies features which satisfy the Surgical and Radiological Departments. The patient can be placed immediately on this stretcher from the ambulance and left there. If minor surgical procedures are required they can be done with the patient on the stretcher.

The general features of the stretcher can be seen in *figures 1, 2,* and *3*. The top of the stretcher is plexiglass. This enables us to place the patient accurately over the wall mounted bucky x-ray apparatus. As can be seen in *figure 2* this bucky can be placed horizontally. It can be moved from one end of the stretcher to the other. Lateral films may be taken with the bucky vertically and the x-ray beam passing horizontally across the stretcher top, *(figure 3)*. The radiographic examination is much facilitated if one has a ceiling mounted x-ray tube. Holes have been drilled in the sides of the metal surrounding the plexiglass. Metal sideboards can be inserted in these holes. At one end of the stretcher is a receptacle into which an intravenous stand can be placed and at the other end is an arm board. We have placed a hydraulic jack at one end of the stretcher so that the foot can be elevated. The head end of the stretcher is hinged. This allows the foot of the stretcher to be elevated in case the patient is in shock. Brakes to fix each wheel have been installed. These allow the stretcher to be completely immobilized for radiography or surgery.

The dimensions of the stretcher are: over-all length, 73.5 ins.; over-all width, 26.5 ins.; length of plexiglass, 71.5 ins.; width of plexiglass, 24 ins.; distance between inside metal bars, 16 ins.; height of stretcher, 32 ins.; distance between lower and upper horizontal bars, 16.5 ins.; distance between vertical end bars, 60 ins.; wheel diameter, 8 ins.; side arms length, 45.5 ins.; and side arm height, 13 ins.

We have been using this stretcher for some months. We feel that it allows surgical procedures and radiographic examinations to be done with comparative ease. The handling and moving of the severely injured patient is reduced to a minimum. The stretcher was built by the engineers in the University Hospital. The cost is comparatively low.

Dr. Duggan is Director of the Department of Radiology, University of Alberta Hospital, Edmonton, Alberta.

Figure 1

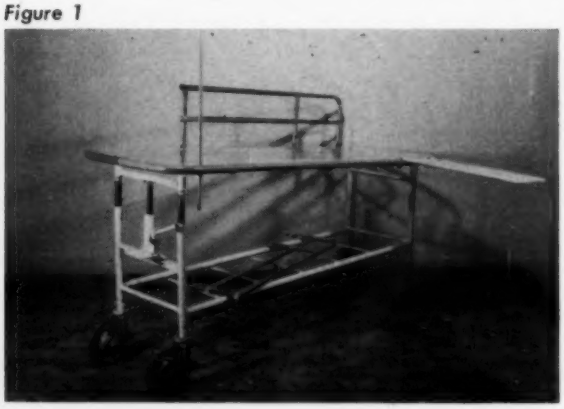
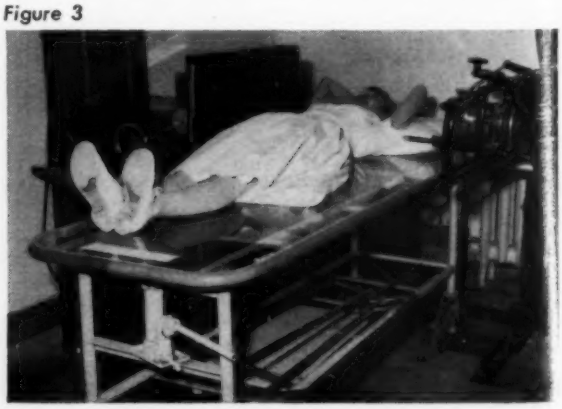


Figure 3



Job Evaluation in the Hospital

Bernard McCarthy
Toronto, Ont.

ADMINISTRATION has been described in varying terms. Some say it is a science, others an art. One commentator has said that it is the art of getting all the credit for all the work done by all the other people. You may also have heard the hospital administrator described as a person who goes around with a worried look on his assistant's face.

Another way of looking at administration is in terms of the functions which the authorities ascribe to it. These are forecasting, planning, organizing, delegating, directing, co-ordinating and controlling. But even these functions are rather abstruse and it seems more meaningful to describe administration in terms of its purpose. This is to use the resources at its disposal, the people, real property, buildings, equipment and chattels, to accomplish the goals of the enterprise as effectively and efficiently as possible. Ray E. Brown, president of the American College of Hospital Administrators and professor of hospital administration at the University of Chicago, has said that the purpose of administration is to influence human behaviour toward the goals of the organization.

This seems a particularly apt way of looking at administration as it applies to the hospital, for there are few types of endeavour in which people are of such major importance and in which things are so unimportant. Making up this preponderance of people are the hospital's patients, employees, medical staff and the public. But most important of all for this discussion are the hospital employees.

Good Employee Relations

Since hospital employees are of such vital and growing importance to effective hospital administration, it is natural that we should be concerned with them and with the climate or conditions under which they work. This climate should be conducive to good *esprit-de-corps*, to enthusiasm, and positive thinking by employees. It should promote, rather than inhibit, satisfaction of the individual employee's needs and aspirations. But what are these normal human needs?

A very basic one is the satisfaction of physical wants. Along with other creatures of our universe, we share the need for food and shelter, but in contrast to lower creatures we find we are not content with merely satisfying our physical needs. We have other aspirations. These have been described in various ways and in varying numbers, but among them are the need for an opportunity to be creative, for self expression, the need for mastery and accomplishment, the need to participate in moulding the world about us, including the world of work in which we spend about one-third of our waking hours.

This being the case, how does the administrator ensure that the needs of his employees are satisfied? In other words, how does he ensure a satisfying work climate?

A clearly defined organization and plan of work are among the most basic requirements for good employee relations. These facilitate communication both upward and downward in the organization and prevent the misunderstandings, confusion and frustrations which ensue where authority and responsibility are not defined, where the goals of the organization are not known and where the plan of work to attain these goals is not understood.

Job descriptions, based on a thorough analysis of each job, are a second essential to successful operation. These enable each employee to know exactly what his job is, what is expected of him, what his duties, responsibilities and conditions of work are, and what rewards and penalties he can expect. Job descriptions facilitate communication and help to give each employee an understanding of his place in the organization, an appreciation of how his work contributes to the total effort — in other words, a feeling of participation.

A sound wage structure is a third requirement for a satisfied work force. By sound we mean one which is, first of all, internally consistent and, insofar as possible, externally consistent. An internally consistent wage structure is one in which wage rates accurately reflect the differences in relative difficulty of jobs. Thus, jobs of comparable difficulty within an organization should carry similar rates of pay. External consistency exists where wage rates in an organization are in line with rates paid by other organizations in the community for similar work.

Selection of the right person for the job is another essential for employee satisfaction and selection should be augmented by on-the-job training so that each employee is encouraged to develop and use, to the fullest extent possible, his natural abilities.

Closely related to training and also essential to an effective and efficient work force is some system of personnel appraisal, a continuing evaluation of the employee in the job as distinct from evaluation of the job itself. Each employee has a need to know how he is doing in relation to what is expected of him and what he must do to improve his performance. To impart such information without arousing antagonism is a difficult task however, and hence this follow-through on employee appraisal is often neglected or, if attempted, it is frequently bungled.

What is Job Evaluation?

Having considered, in general, some of the requirements for good employee relations, let us look more closely at one of these — a sound wage structure. We said that this should, insofar as possible, be internally and externally consistent. Differences in rates of pay for comparable jobs within an organization are a particularly common cause of employee disgruntlement. Employees rankle under such inequities and this is understandable. Most people have a strong sense of fair play and perceive this as violating

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The author is an administrative assistant with the Ontario Hospital Association. He gave this paper at the annual convention of the Ontario Conference of the Catholic Hospital Association in Toronto, Ont., October 1959.

the rules of the game. They expect the administrator as both referee and manager to see that the rules are observed.

In a large departmentalized enterprise, with many levels of authority, it is unlikely that the administrator can be thoroughly familiar with each job and hence it is difficult for him to ensure that his wage structure is fair and reasonable. But one way of doing this is through a formal job evaluation program which consists of systematically analyzing and ranking each job according to relative difficulty and developing wage rates which reflect these differences and which recognize community rates for comparable jobs.

We should note that the idea of evaluating jobs is not new, for in one way or another this has been done ever since the first man hired an assistant and the first organization was begun. What is a more recent development, however, is the formal or systematic approach, and this has been made necessary by the trend toward "bigness" of our present-day organizations. Hospitals, as we know, have not been excepted from this pressure.

It is important to note also that despite methodical study and refined methods, job evaluation is not an exact science. There are no precision instruments with which we can weigh or measure the relative difficulty of jobs. Its results are based on opinion, but it is the considered opinion of an experienced group of people after careful review of the facts recorded in job descriptions. As such, it is one of the most reliable and acceptable methods known for determining the relative difficulty of jobs within an organization, relating these to comparable jobs in the community outside and developing a wage structure which makes sense to people both inside and out.

Undertaking a Study

Job evaluation, as we have said, is a valuable aid to the administrator, but of course it comes at a price. In addition to the initial expenditure of time required to conduct the study, there is the continuing cost of keeping it up to date. Living organizations as well as living organisms are characterized by change and, if the initial expenditure in job evaluation is not to be lost, the information must be continuously reviewed and revised.

With these perquisites taken care of, the major steps in the study are:

- Explanation of the program to department heads and gradually to all personnel. Each employee should understand what is being done and be assured that his wages or job security will not be adversely affected.
- Introduction of job questionnaires within a department.
- Analysis and description of each job in this department, as to duties, responsibilities, authority, initiative, education, training and experience required.
- Ranking of jobs within the department in order of relative difficulty.
- Grouping of jobs into grades or classes according to relative difficulty. Differences in difficulty between classes of eight to ten per cent are considered to be about the minimum which one can identify.
- Extension of the study to other departments so that all are eventually included.
- Comparison of job classification among departments to ensure consistency throughout the organization.
- Survey of community wage rates for a few sample jobs selected from each category.
- Development of a salary structure which takes into consideration the findings of the study in regard to the relative ranking of jobs and the difference between them. Also to be considered are the current rates of pay within the organization and the community rates for comparable jobs.
- Development of a plan for gradually implementing the changes indicated.

In addition to being the basis for job evaluation, job analyses and descriptions may aid many other aspects of administration and employee relations. A job evaluation study may have a number of valuable side effects. It may, for example, throw light on organization and methods improvements or on improvements in supervision which may be desirable. Also, of course, job descriptions are useful in recruiting, selection, placement and training and development.

The Changing Scene

Those who had the opportunity of hearing Ray Brown speak on administration during the Ontario Hospital Association Convention will recall his suggestion that hospital administration more than the administration of most other enterprises requires a fine balancing or mixing of some mutually opposing considerations. It was his opinio that, in the past, the human dime sion, or employee relations dime sion, of hospital operation had be neglected. More concern and er phasis on this is now required, said. Others associated with t field have made similar obser tions. Dr. Albert Snoke when pre dent of the American Hospital A sociation in 1957, suggested th hospital wages would have to competitive with the community hospitals are to function proper He suggested that in some ca s the hospital employee had been " involuntary philanthropist". In t Ontario Legislature, this year, t Hon. Charles Daley, Minister Labour, likewise stated that he h given his blessing to organized bour to enter hospitals a few yea s ago as a means of improving wor ing conditions.

Others not so close to the hospit l scene have made similar comment . An editorial in the New Yo k Times, following settlement of th prolonged strike of employees at several hospitals in New York City last June, contained this statement:

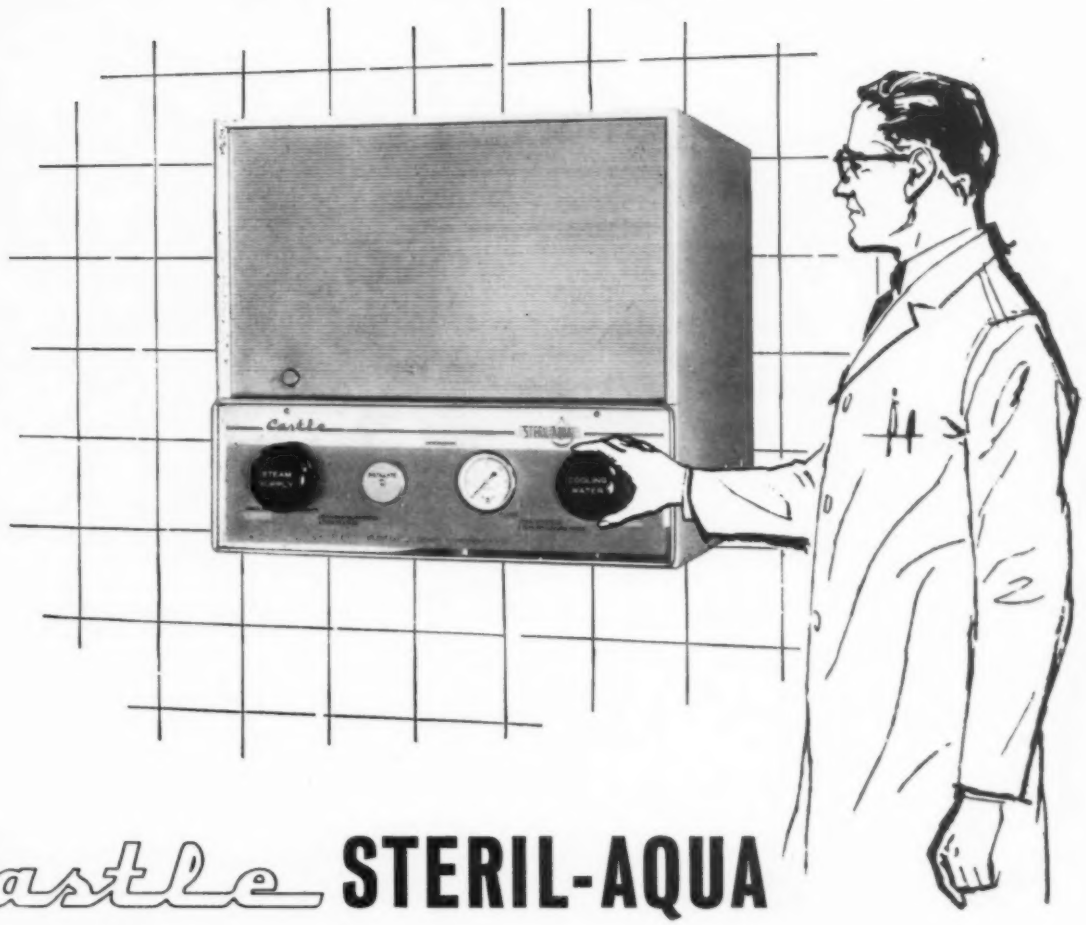
"The community's interest in this labour dispute now ended centres chiefly on seeing to it that from now on the hospital employees get humane pay for humane work. City and state governments and the public through its philanthropic gifts must not relax until these workers are fairly paid."

The American Hospital Association three years ago prepared a statement on hospital personnel policy which contained, in essence, much of what these commentators have said. It also included much of the ground which I have attempted to cover in outlining the rôle of a job evaluation program in hospital administration.

Here in Ontario, and in most other provinces of Canada, the people through their governments have recognized that hospital care is a necessary service in the community. Hospitals have been guaranteed their operating costs and have been freed from the burden of annual operating deficits. The experience to date indicates that this has been a blessing, but wit it comes new pressures and new challenges for hospital administration. With the cost of hospital car now distributed through taxatio and premiums over the total popu lation, hospitals have been trans formed from charitable to servic organizations. The plea of inabilit

(concluded on page 104)

Today's most efficient still is today's most compact still . . .



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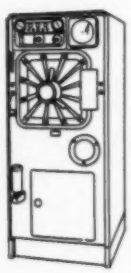

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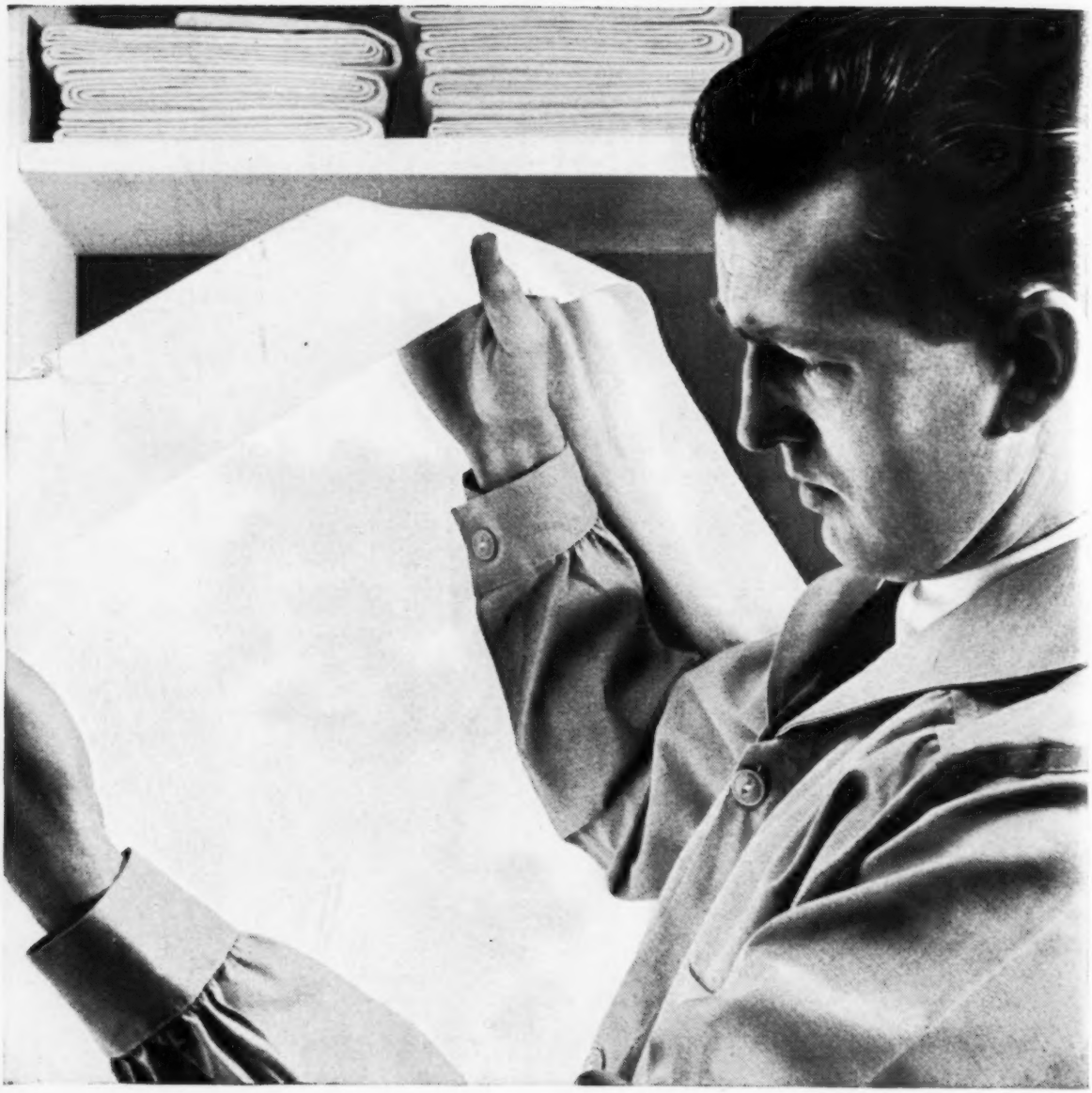

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Have you ever asked the patient?

Claude E. Dosdall,
St. Catharines, Ont.

ON the first of July, 1958, this hospital introduced a patient comment form which has been in use for 15 months. At the time the use of a patient comment form was discussed there was some speculation as to the type of form to use. Should the comment form ask specific questions whereby the patient would state whether the service in each specific area was good, satisfactory or poor or should the comment form be "open"? By an open form I am referring to a letter addressed to the patient which requests his constructive criticism or any comment he wishes to make. The administrator and department heads considered the "open" type of form the most desirable at the outset. The philosophy was that this type of form does not direct the patient's comments into designated channels but rather gives the patient greater scope to outline his true feelings. It was felt that the comment form which would ask questions such as "Was the food hot?" was directing the patient's thinking into narrow channels and that answers to such questions would do little to improve patient care. If a patient had a complaint he should be able to recall this when completing the form without being proded by specific questions.

This open form has proved to be very satisfactory in obtaining a wide range of diverse comments from the patients. Patients have commented on almost every department in the hospital at one time or another and one gentleman even used the patient comment form as an application form to apply for a job. How else can a comment form obtain such versatility!

Mr. Dosdall is administrative resident of St. Catharines General Hospital, St. Catharines, Ont.

When does the patient receive the comment form?

Patient comment forms are kept on each floor and are given to the patient by the ward secretary or nurse as soon as the time of discharge is known. This means that a patient usually receives the form about one or two hours before leaving the hospital. The immediate question which arises from this is, "Does the patient have sufficient time to fill out this form?" This is perhaps debatable but generally speaking I feel he has sufficient time. Although, on occasion, the patient may be rushed, he nevertheless does have sufficient time to fill out the form if the things he wishes to mention are foremost in his mind. I feel that it is unnecessary for the patient to have a great deal of time to think of things which are supposedly wrong with the hospital. If something has been obviously irritating to the patient during his stay in the hospital, he will remember it. The other alternative which the patient has is to take the form home and return it by mail, thereby giving him unlimited time for thought.

What happens to the completed forms?

The head nurse generally reviews the comment form before the patient leaves and hence can discuss any matter with the patient which she feels she may be capable of clarifying. For example, if the patient has complained of not receiving a cup of coffee at night, the head nurse will explain to the patient that it was available had he asked for it. Often such a complaint is merely due to a misunderstanding which can be readily cleared up by a simple explanation.

All adverse comments are then withdrawn and sent to the administrator for his study. These adverse comments amount to approximately 4.5 per cent of all completed patient comment sheets. The administrator selects any adverse comments which he feels are remedial and presents them to the appropriate department heads for action. For example, if the patient has complained of a squeaky bed or a leaking faucet in his room, the maintenance department will be contacted. This type of constructive comment is acted upon as quickly as possible.

The procedure just outlined has been in existence at the St. Catharines General Hospital for over one year. Although it has proved satisfactory and the staff feels that it has been helpful in improving patient care, it has, nevertheless, been recently altered so that the comment sheet is now sent directly to the administrator.

Under the current system, the comment forms are placed by the patient in an envelope addressed "Administrator". This system, on a trial basis, has only been in existence for a short time and so far there has been no noticeable difference in the comments; and comments about the nursing staff have continued to be generally complimentary as in the past.

Analysis of Patient Comment Forms

On reviewing the patient comment forms for the one year period

(continued on page 98)

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Fluctuating the Nursing Staff according to patient load

J. A. Ritchie
Sweetsburg, Que.

THE steady upswing in the cost of hospital service is showing no immediate sign of levelling off. For years it has risen with the cost of living and the need to employ more and more technical and professional personnel. To ease the load, the sick and the well have combined to pay the bill and to-day sharing of the cost of illness is spread out among a larger number of the population than ever before. Even though more payments are now made indirectly through the various insuring agencies, private and governmental, the general public is reminded of the increasing cost each time insurance rates are adjusted upward. Focussing of attention and criticism will continue to be directed toward hospital boards and those concerned with management. The use of controls and evaluation of performance will not be less important in the future.

The item that will probably receive the greatest scrutiny is salaries and wages since it makes up over 65 per cent of the total hospital expense budget. Staffing presents many problems for serious consideration and not the least of them is how best to cope with the fluctuating patient load which occurs in most hospitals from day to day. What policy should be established to provide a high standard of service at all times without waste in personnel employment?

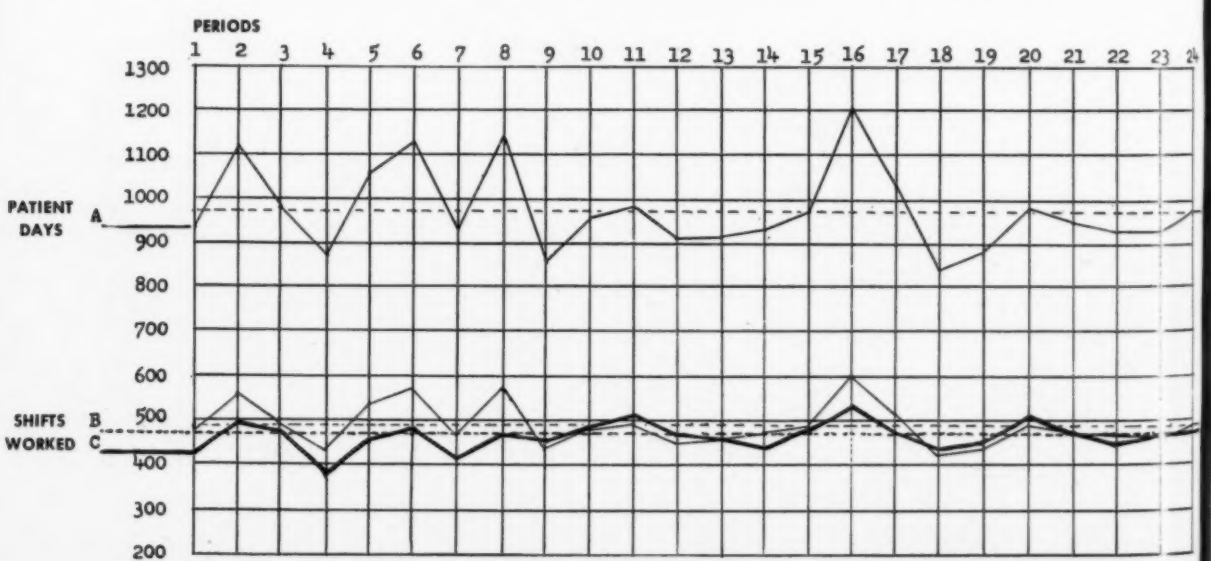
Looking back on past experience, graphs depicting hospital occupancy present a series of peaks and lows. Except for hospitals in growing communities these minimum and maximum peaks will be above and below the horizontal straight line average for the year. With this in mind, when staff planning for the year ahead, should the total number of full-time personnel in each department be based on peak load requirement or should the number be determined by the average load requirement? Insofar as low periods of occupancy are concerned, there are probably no situations where it would be possible to employ full-time personnel on the basis of minimum loads and relief personnel added and adjusted as the load increases above minimum.

In many departments there is no choice because, in some categories trained people who wish to work part-time only may not be available in the community. In these departments the peak load determines the number needed on the full-time staff and the personnel may be utilized otherwise during times of low occupancy or shared with other departments. In the nursing department, and this usually covers the largest part of the salary budget, a choice of planning is available in most communities because of the graduate nurses and other trained nursing personnel who can and wish to work on a part-time basis only.

The experience of a 75-bed general hospital, extending over 24 two-week periods is reviewed here. At the beginning of the period the objective was defined as staffing with full-time personnel for the average expected load and utilizing relief workers in direct proportion to the increase above average. Making no distinction between the different nursing areas it was agreed that in our situation an average service of four nursing hours per patient day for the whole hospital would be adequate. The hospital has two nursing units and a review of the previous twelve months' experience in occupancy showed that the average daily census in each unit was 32, and occupancy had not changed appreciably over the past several years. The expected average patient census for the hospital was there-

(concluded on page 102)

Mr. Ritchie is the Administrator of Hôpital Brome-Missisquoi-Perkins, Sweetsburg, Que.



Book Reviews

REPORT OF THE FIRST INSTITUTE ON CLINICAL TEACHING (The sixth A.A.M.C. Teaching Institute). Edited by Helen Hofer Gee and Julius B. Richmond. Published by the Association of American Medical Colleges, Evanston, Ill., 1959. Pp. 233. Price clothbound, $3.00; paperbound, $2.00.

The 1958 Institute on Clinical Teaching, the first in a series of two, reveals what problems teachers of clinical medicine find most pressing. Considerations range from expressions of opinion on philosophies of scholarship and education to challenges to face practical issues arising out of social and economic change.

The book reports the conference proceedings and also the results of a pre-Institute survey of medical school and hospital administrators and clinical teaching faculties. It is organized to follow the broad topic areas of the Institute. The 17 writers represent medical education, university administration, hospital administration and the social and behavioural sciences.

THE MASSACHUSETTS GENERAL HOSPITAL 1935-1955, by Nathaniel W. Faxon, M.D. Published in Canada by S. J. Reginald Saunders and Company Limited, Toronto, 1959. Pp. 490. Price $11.95.

The Massachusetts General Hospital has had its history ably recounted from its beginning in 1811. The story of the hospital's major activities and accomplishments is now comprehensively continued by Dr. Faxon, who is Director Emeritus of the Massachusetts General Hospital and the Massachusetts Eye and Ear Infirmary. Dr. Faxon shows how the three major functions of a hospital have been successfully amalgamated during these 20 years—the structural expansion of the hospital from a single building to the present group of 14 major buildings and many smaller ones has extended facilities for the hospital's primary function — the care of the sick. The two other major functions of a hospital—teaching and research — are also discussed. The educational functions of the Massachusetts General Hospital began through its association with the Harvard Medical School and now provides for nearly a thousand students annually. Formal educational programs besides those in medicine and nursing, *e.g.* in the Dietary Department, the School of Medical Illustration et cetera are also clearly explained. In the field of research outstanding developments have been made. A building devoted entirely to research has been erected. The contributions of the staff in the various fields of research are outlined.

Events are chronologically presented by single years, a chapter to each year, followed by the treatment of some subjects in greater detail *e.g.* anaesthesia, radiology, the tumor clinic, the blood bank and physical medicine. The contribution of women's organizations receives attention and also how the problems of wartime were met.

Those who have been connected with the Massachusetts General Hospital will be particularly interested in this book and proud of the hospital's accomplishments, but it is also of general interest from the point of view of medical and hospital history.

HOSPITAL TRUSTEESHIP, by Charles U. Letourneau, M.D., Starling Publications, Chicago, 1959. Pp. 480. Price $7.50 (U.S.).

Intended as a handbook for hospital trustees, this book outlines the trustee's rights and responsibilities and delves into his relationships with the administrator, the physicians, the hospital staff and his fellow trustees. There are sections on the history and organization of hospitals, the qualifications and duties of the administrator, the organization and functions of the medical staff and general discussion of hospital policies, financing, accreditation and evaluation. These inform the trustee as to what is expected of him and what he should expect from the people with whom he works.

Inclusion of appendices detailing by-laws, rules and regulations of the hospital, and a questionnaire by which the trustee can test his knowledge of his own institution, further strengthen the book. Dr. Letourneau holds degrees in medicine, law, and hospital administration and, as a recognized authority in the hospital field, he is well qualified to write on this subject. Although the experienced trustee may consider some of the material elementary, the inexperienced trustee must beware of over-simplification. The book is valuable as a basic reader for trustees and as an introduction to the hospital for a new member of the board.

THE HISTORY OF NURSING, by Richard H. Shryock, Ph.D. Published by the W. B. Saunders Company, Philadelphia and London, 1959. Pp. 330. Price $5.00.

The purpose of this book is to present the story of nursing in close relation to its scientific and social background. It describes the care of the sick from the primitive tribe with pagan ideals to the modern urban nursing centre of today. For if one is to understand the emergence of modern nursing one must relate it to social history. But nursing has also been influenced by the nature of medical practice and so medical history has been included in this study, noting for each period how nursing was affected by medical practice, by medical institutions, and by the medical profession. It is the author's hope that immediate tasks will take on a new significance when fitted into their place in a long and yet unfinished epic.

Emergency Measures Organization

The Ontario Government has completely reorganized its civil defence setup, and the new Emergency Measures Organization has much broader jurisdictions and responsibilities than the Civil Defence Branch which it replaces.

The chairman of the new body is Fire Marshal W. J. Scott, Q.C. Besides responsibility in case of atomic warfare, the Emergency Measures Organization has been given responsibility in cases of natural disaster. The new 1959 dominion — provincial Workmen's Compensation Agreement between the Federal Government and the Government of Ontario provides for the first time that there will be compensation coverage for volunteer workers who may be called out in a natural disaster.

—*Ontario Government Services*

Efficient Kitchen Planning

Margaret Ketchen,
B.H.Ec., R.P.Dt.
Toronto, Ontario

THE people who to-day are in charge of food services are keenly aware of rising food costs. Every effort must be made to 'stem the tide'. In organizing any kitchen —whether it be completely new or renovated, the first consideration must be to produce good food. The second, and almost as important, is to plan all details of that operation so that the amounts of raw food are controlled and the hours of labour kept to a minimum. These factors should be considered in the earliest stages of planning. Centralization of essential services reduces the amount of equipment. Less supervision is needed when preparation is carried out in one central unit, rather than in scattered areas. It is also possible to save food by better utilization of leftovers when preparation and service are centralized.

In food production as in manufacturing, one of the best ways to decrease labour costs is to reduce 'handling'. In a kitchen this includes transportation of food stuffs, raw and in various stages of preparation, clean and soiled dishes, utensils, etc. By applying 'automation' to the departmental organization, trucking may be reduced and many waste motions eliminated.

Using an imaginary flow chart, let us consider the equipment which will reduce the number of times each item is handled. At the receiving dock a number of platform trucks, designed for this specific purpose, should be available. These trucks are later used for storing food, either in refrigerators or in the storeroom in place of fixed shelving. Organization on the loading dock will avoid duplicate handling later if sufficient trucks are available and the workers know how distribution is to be arranged. Adequate refrigeration using separate units for various types of food is of the utmost importance.

Miss Ketchen is director of nutrition, Toronto General Hospital, Toronto, Ontario.

If all refrigerators are built with flush floors, duplication of handling is avoided by using trucks for storage of all supplies. Very flexible systems of storage and handling may be worked out in this way.

On the receiving dock a meat rail complete with scales will ensure that the cuts of meat reach the butchershop with few waste motions. 'Fork lift' trucks are used to transport and deposit cases of food in large quantities. These are expensive but should be listed among labour saving devices.

An Ingredient Control Room, planned to provide the preparation areas with raw materials in the exact amounts needed, is an excellent way to control supplies. With this system centralization of 'leftovers' is possible. Ingredients are sent from the Control Room weighed as needed to each preparation area. Canned and frozen foods are opened in this centre, with the result that cartons and tins never reach the kitchen—surely a saving in the amount of garbage to be handled! If the room is large enough and the proper equipment has been provided, rough preparation may be carried on here, and this further reduces garbage transportation.

But simplified methods of receiving, storage and distribution are not enough. Simplified methods of processing, serving and dishwashing must follow.

Portable equipment — supply tables, landing tables, cooking racks and pot racks, both for clean and soiled utensils, save thousands of steps for workers. Portable tables for pie rollers, bun dividers, toasters, food choppers and small mixers make it possible to use these units in many locations. Grouping of equipment and tools stored at strategic points saves the energies of skilled and unskilled workers alike. Dollies for mixer bowls, dish racks and garbage tins are also very useful. Tanks for steamer baskets of prepared vegetables are another type of portable equipment which soon pays for itself. All portable equipment should have two of the casters with locking devices.

In food preparation, a great many types of cutters and shredders are available. These all reduce hand labour as well as handling. Mechanical aids in the bakeshop include pie rollers, tart machines, cookie droppers, doughnut makers, bun dividers and moulders.

Some of these units are suitable only for kitchens preparing a large volume of food. So the work load should be estimated before spending too much money. But it must be remembered that any piece of equipment costing up to $6000 will pay for itself in less than three years if the services of one worker are eliminated by its use.

Dish dispensers should be considered as a sound investment. Portable units seems to be more useful than those built into serving counters, et cetera. It is necessary to truck dishes to the latter for loading, and this is extra handling. Labour saved by using this method for storing dishes more than compensates for the additional expense. Dishes are always available as they are needed, in any location. There are several kinds of dispensers now made—one for each type of dish. Plates of all sizes, fruits, cereals, et cetera are stored in 'stacks'. Racks for the dispensers take care of bouillon cups, creamers, tea pots, thermos jugs, sherbets and glasses, et cetera. Combination dispensers accommodate racks of cups and stacks of saucers. Using the same principle, portable dispensers keep sliced bread in good condition till it is needed. After the meal service, soiled dishes are put into racks and passed through the dish machine, then stored in the dispensers till needed. It is possible to have these units electrically heated for serving hot food. If chilled dishes are desired, the unit may be wheeled

(concluded on page 68)

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into a refrigerator. Heated units are more expensive than the 'cantilever' type, but the latter have an added advantage. As the dishes are used, space is available for storing the empty racks, under the filled compartments. As the racks used are of different heights, capacity, et cetera for the different dishes, a good method of identification is to have the corners painted in various colors.

In dishwashing, the system of dish dispensers and racks which we have already discussed, reduces labour and dish breakage. Much research has been done on detergents and 'wetting' agents. For large installations the 'Flight type' dish machines reduce labour and make possible sterilized sparkling dishes, glasses and silver ware. Mechanical pot washers are now being manufactured which take much of the labour and drudgery out of this operation.

It is necessary if dish dispenser are to be used to have wide aisle for transportation. In planning new counter, space for variou types of dispensers should be a lowed, so that these units may eac be stored in its required place.

In serving meals, assembli trays and returning soiled dishe conveyor belts are being wide used. The set-up around any ty of assembly or tray stripping li should be flexible. Portable equi ment makes this possible by pr viding the variety of service uni needed for any given menu. Ser ing pans which fit into electrical heated or steam tables are used ovens and steamers. This sav much handling and reduces p washing.

Pass-through units behind se vice lines may be refrigerated or electrically heated. This mea s that reserves of all types of foo are ready at the correct tempe ature with little if any truckin of supplies to the serving centre A pass-through return unit allow soiled inserts to be readily col lected.

With the complicated arrange ments of equipment seen in modern kitchens, it is most important to have efficient supervision, and ade quate maintenance. This should be considered when the plans are made.

Original planning should take into consideration sanitation as well as safety precautions. The former includes care of walls, floors, drains, et cetera. These physical details require many hours for maintenance and cleaning. Equipment itself must be well constructed, of durable material. The most economical to use is heavy gauge stainless steel. Initial outlay is expensive, but the fact that it lasts for years and is extremely durable more than offsets the initial cost. There are several details of construction which, when included in the original specifications increase the ease of cleaning.

In closing I would like to stress very strongly the need for efficient organization and constant super vision. The most efficient equip ment in the world is useless with out a staff trained to make the best possible use of it and to keep i clean and in good running order.

When a kitchen has been properly planned, and is being efficiently operated, one of the worst enemies of controlled man hours — unpro ductive waste motions — will have disappeared. ■

Coming Conventions

May 9 - 12—O.H.A. - A.C.H.A. Third Basic Institute for Hospital Administrators, Park Plaza Hotel, Toronto, Ont.

May 18 - 20—Medico-moral Institute (Catholic Hospital Conference of Saskatchewan) Bessborough Hotel, Saskatoon, Sask.

May 23 - 25 — Canadian Hospital Association Assembly Meeting, Park Plaza Hotel, Toronto, Ontario.

May 30 - June 2—Catholic Hospital Association of the United States, annual convention, Milwaukee, Wis.

June 12-16—The Canadian Society of Laboratory Technologists, 24th national convention and annual meeting, Sheraton-Mt. Royal Hotel, Montreal, Que.

June 13-17—Canadian Medical Association, Annual Meeting, Banff, Alta.

June 13 - 17—Canadian Society of Radiological Technicians, 18th convention, Macdonald Hotel, Edmonton, Alta.

June 14 - 16—Canadian Dietetic Association, Queen Elizabeth Hotel, Montreal, Que.

June 19-24—Canadian Nurses' Association, biennial meeting, Nova Scotian Hotel, Halifax, N.S.

June 22-25—Canadian Physiotherapy Association, annual convention, Vancouver, B.C.

June 27-29—Comité des Hôpitaux du Québec, annual convention, Provincial Exhibition Grounds, Quebec City, Que.

June 28-July 1 — Maritime Hospital Association, Algonquin Hotel, St. Andrews, N.B.

July 4 - 8—Annual Institutional Laundry Institute, Ontario Agricultural College, Guelph, Ont.

Aug. 28 - Sept. 2—International Society for the Welfare of Cripples, Eighth World Congress, Waldorf-Astoria, New York.

Aug. 29 - Sept. 1—American Hospital Association convention, San Francisco, California.

Sept. 5—Catholic Hospital Conference of B.C., annual meeting, Vancouver.

Sept. 6-9—Western Canada Institute for Hospital Administrators and Trustees, Queen Elizabeth Auditorium, Vancouver, B.C.

Sept. 20-21—Catholic Hospital Conference of Alberta, 17th annual meeting, Jubilee Auditorium, Edmonton, Alta.

Oct. 10 - 11 — Catholic Hospital Conference of Saskatchewan, Bessborough Hotel, Saskatoon, Sask.

Oct. 10-14—American College of Surgeons, 46th Annual Clinical Congress, San Francisco, Calif.

Oct. 12-14—Saskatchewan Hospital Association, annual meeting and convention, The Bessborough Hotel, Saskatoon, Sask.

Oct. 18-20—Manitoba Hospital and Nursing Conference, Winnipeg.

Oct. 24-26—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 25-27—Associated Hospitals of Alberta, Northern Alberta Jubilee Auditorium, Edmonton, Alta.

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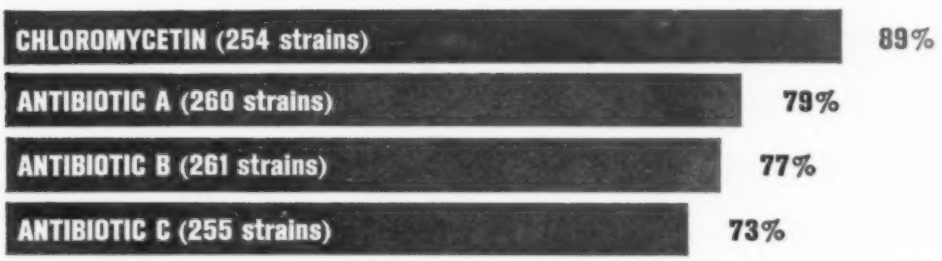

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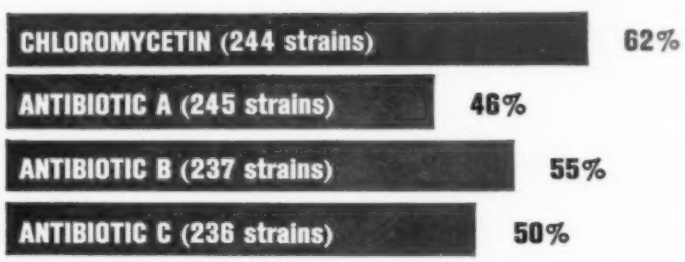

*Adapted from Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414.

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Provincial Notes

British Columbia

Working drawings are expected to be completed shortly for the construction of a 195-bed nurses' residence and training school for the Royal Columbian Hospital, New Westminster. Teaching facilities will include lecture rooms, instructors' offices, study rooms, a library and auditorium, and science and diet laboratories. The project also includes alterations and renovations to the existing 61-bed nurses' residence, which will provide an additional 10 beds making an over-all total of 266 beds. It is estimated that the new eight storey reinforced concrete building will cost approximately $1,500,000. Architects for the project are Townley and Matheson, Vancouver.

The Hon. Eric Martin, Minister of Health and Welfare for B.C. opened the new Kitimat General Hospital, Kitimat, in March. Cost of the new four storey building is $2,544,000 of which the provincial government's grant of 50 per cent of the approved costs will total over $1,272,000, plus additional grants for equipment and furnishings. Built in the shape of a "T", the new hospital is constructed of reinforced concrete and will provide 85 beds. It has unfinished areas which, when completed, will increase the bed capacity to 113 beds. Also included are facilities for a Public Health Unit. Architect was Fred S. Brodie of Thompson, Berwick and Pratt, Vancouver.

Gorge Road Hospital, for the chronically ill, Victoria, is planning an immediate $50,000 addition to its rehabilitation facilities and has long-range plans for a 50-bed addition expected to cost about $500,000.

In the year 1959 a total of 3,308 books and approximately 1,500 magazines and paperbacks were circulated from the hospital library to the patients of St. Vincent's Hospital, Vancouver.

In the University of B.C. medical school a new and unique department for continuing medical education is to be formed under Dr. Donald Williams. It will be the beginning of a closer relationship between the university and practising doctors.

Alberta

Work has been commenced on the new municipal hospital in Peace River. Plans are for a 70-bed three-storey structure with provision for adding another storey when necessary.

A new Charles Camsell Indian hospital, estimated to cost $8,500,000, is planned for Edmonton. The building is to be immediately north of the present hospital which was opened in 1946. The new structure is expected to contain 450 beds. The present hospital has 420 patients, including Indians from Alberta, the Northwest Territories and the Yukon, Eskimos, and Metis from the Northwest Territories.

A second storey will be added to the Taber Municipal Hospital this summer. Cost is estimated at $120,000.

Calgary has a Nursing Home Association, the aim of which is the improvement of standards in nursing homes. Dr. G. P. Mores from the provincial department of health is resident inspector of nursing homes.

Saskatchewan

The Regina General Hospital has announced a new student nurse training program similar to some in operation in Eastern Canada. The program calls for two years' training in basic theory and supervised practice in hospital, followed by a year of internship. Students will not be expected to carry any responsibility for services in the first two years of the course, which is expected to go into effect in September, 1960.

The new Lac La Ronge hospital has been opened. The hospital has 25 beds and five bassinets. A nurses' residence located just north of the east wing of the hospital, is due to be opened soon. The hospital has an acoustic ceiling, in which every piece of the ceiling can be removed, and each ward is individually piped with oxygen.

A 36-bed hospital is to be bui in Leader. It is to be a sing storey structure without a bas ment, approximately 221 feet 147 feet. The new building will constructed just south of the pr sent Leader Union Hospital.

A gift of $18,500 for various r search projects has been made the University of Saskatchewan the Saskatchewan Heart Fou ation.

Manitoba

The $42,500 addition to t Glenboro Medical Nursing U was opened in March. The additi contains 18 beds. So far grants $14,000 have been received fro both the federal and the provinci governments. The addition w built on the two-third and one-thi share cost basis with the hospit area bearing the one-third share cost.

Ontario

The construction of the Joseph Brant Memorial Hospital, Burlington, is to be advanced beyond the original plans to include a sixth floor to bring the total bed capacity to some 222 beds. A new committee which was formed last year at the hospital was the Human Relations and Personnel Committee. In addition to assisting with the selection of personnel, this committee is charged with recommending policies that will assure friendly, thoughtful and consistently good care of the sick and injured and with assisting the board in setting up an organization with clearly defined lines of authority for the personnel of the hospital.

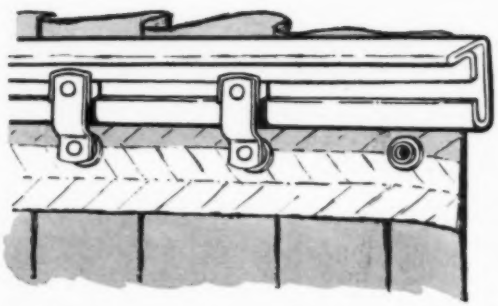
Construction work at the Ontario Government Hospital for Retarded Children at Cedar Springs, near Chatham, is well ahead of schedule. There are medical and surgery buildings, trades buildings and a school for retarded children. All buildings are connected by tunnels. The school will be fully equipped to carry on the education of the children to the limit of their capabilities. It is expected that children well be accommodated at the hospital this fall.

Plans are now complete and tenders being called for a new clinical services building which will add 360 beds to the Ontario Hospital Port Arthur. The new fireproofed building will consist of three separate wings, inter-connected by en-

(continued on page 110)

SPEED

putting drapes up or taking them down with new Kirsch Safe-Snap* Drapery Tape



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Notes on Federal Grants

Construction

The Toronto General Hospital, Toronto, Ont. has been awarded federal grants amounting to $106,300. The grants will be used to assist in the costs of alterations which will provide for the expansion of out-patient facilities, provision of an enlarged medical photography department and improvement to kitchen services. An additional 14 active treatment beds will also be provided in the private patients' pavilion.

Grants totalling $259,800 have been awarded to the Pathological Institute, Halifax, N.S. Approximately $207,000 will be used to help construct a new steel and concrete building which will provide increased facilities for laboratories dealing with pathology, virology, bacteriology, haematology and other aspects of pathological services. The remainder of the grant, about $52,500 will be used to help meet the costs of renovating the existing building.

Addition of a new section to the existing Morris General Hospital, Morris, Man., will be undertaken with the assistance of a $92,800 grant. This will increase present capacity by 34 treatment beds and 16 nurses' residence beds and provide for clinical and diagnostic areas. Extensive renovations to the existing hospital will also be carried out.

The Western Hospital, Alberton, P.E.I., will receive $81,400 to assist in building an addition to the existing hospital. When the new construction is completed, the hospital's capacity will be 49 patient beds, 8 bassinets and 14 nurses' beds.

To assist in the construction of a new three-storey wing a grant of $235,800 has been made to the Great War Memorial Hospital of Perth District, Ont. The project will increase the bed capacity by 49 beds and provide for 10 additional bassinets. A surgical suite, central supply service, emergency room and x-ray department will also be incorporated in the new wing. The original hospital building will be renovated and converted for use for administration offices, physio-therapy, a records room and other medical services.

The sum of $118,600 has been granted to the Kingston General Hospital, Kingston, Ont. to assist in the construction of a new wing and renovation of existing space which will provide for an additional 11 patient beds, enlarged kitchen and dining rooms, formula preparation and bottle wash areas, storage space and staff facilities.

Towards the cost of a self-contained wing, the Calgary General Hospital, Calgary, Alta., has received a grant of $205,000. The new wing will accommodate 205 long-term active treatment patients and extensive rehabilitation services.

The Peterborough Civic Hospital will receive $409,000 which will be used to assist in adding extensions to four sections of the hospital and provide for a new laboratory, additional dining areas, operating rooms, nursing administration and social workers' offices. Re-arrangement of patient areas will result in an increase of 41 patient beds and 98 chronic beds.

Provision of additional accommodation for nurses and nurses' training facilities, modernization of two floors in the present nurses' residence and the conversion of a large, open ward into private, semi-private and 3-bed rooms at the Toronto Western Hospital, Toronto, Ont., will be made possible with the assistance of health grants amounting to $149,000.

A renovation program, which will result in a modern, air-conditioned area for the electroencephalograph and electrocardiograph departments at the Winnipeg General Hospital, Winnipeg, Man., will be assisted by a grant of $32,300.

Equipment

Several Quebec hospitals have received grants to assist in the purchase of new x-ray and laboratory equipment which will facilitate treatment and diagnostic services. Hospitals receiving the grants are: Hôtel-Dieu de Levis, Levis, $53,150; Hôtel-Dieu Notre-Dame de Beauce, St-Georges-Ouest, $36,500; Hôpital de la Visitation, Montreal, $20,400; Hôtel-Dieu St- Michel, Roberval, $7,400; Hôpital St-Joseph, Lachine, $32,400; Hôpital du Sacr Coeur, Hull, $36,100; Hôpital S Joseph, Thetford Mines, $22,50 Hôpital du Sacré-Coeur, Montrea $50,500; and Hôpital St-Louis Windsor Inc., Windsor, $23,700.

Education

The sum of $39,400 has bee awarded to the Department Psychiatry, University of Briti Columbia, Vancouver, to assist the development of extensive pos graduate studies at the unive sity. From the courses provided, supply of well-trained psychi trists will be available to ser in provincial mental institutio and community clinics in B.C.

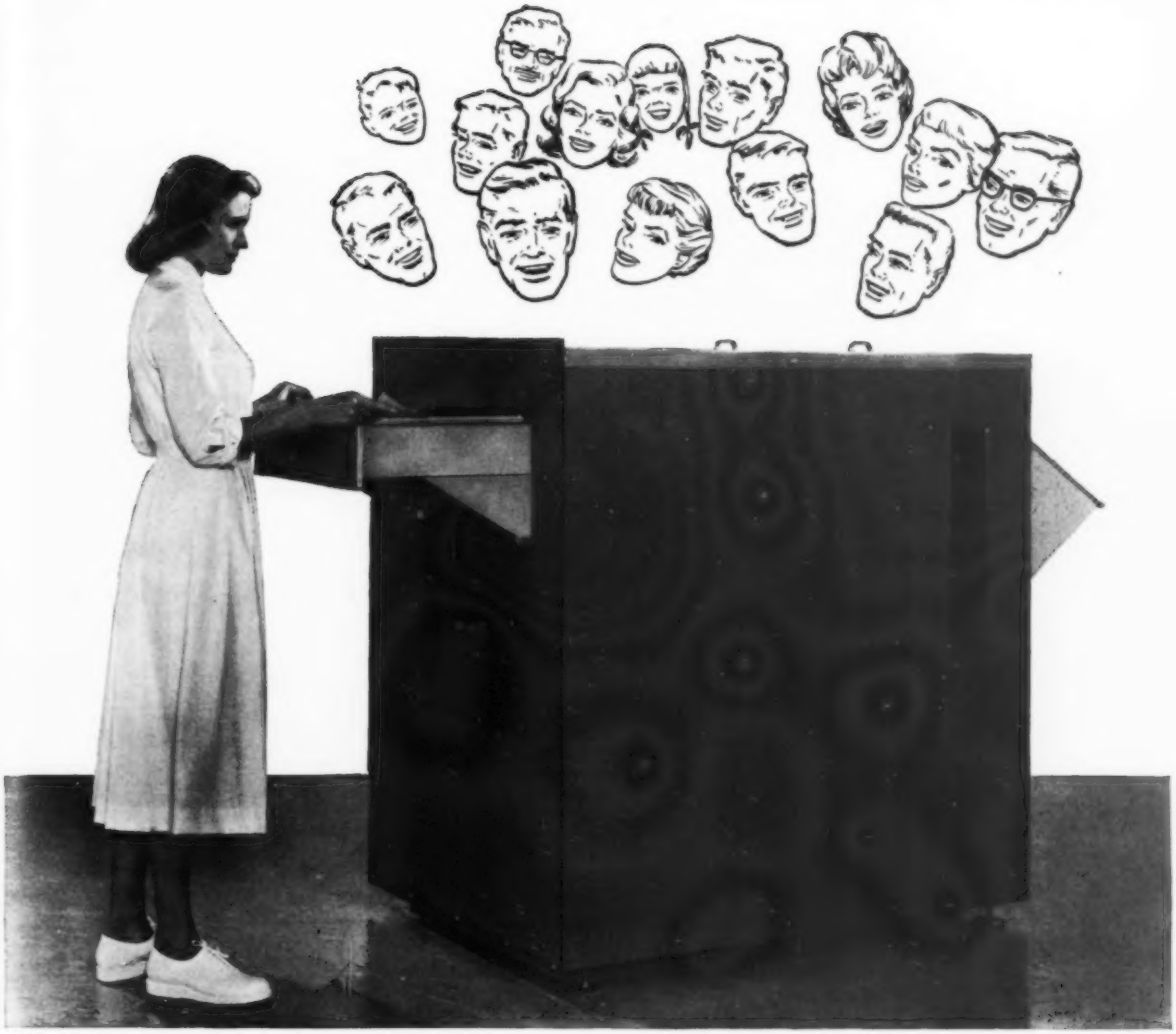
Public Health

Establishment of a new healt unit to provide full-time publi health services in the Shoal Lak —Birtle—Russell—Roblin area o Manitoba will be assisted by a health grant of $17,600. The uni will provide full-time publi health services to approximately 22,000 people comprising the residents of 11 rural municipalities, two towns and six villages.

C.S.R.T. 18th Annual Convention

The convention program of the Canadian Society of Radiological Technicians being held in Edmonton, Alberta, June 13-17, provides for a pre-convention fellowship course held June 6-10, at the University of Alberta, where accommodation and meals are arranged for $6.00 per day in addition to the cost of the course proper. The course covers subjects such as education, physics and basic sciences, radiation, radiography, anatomy, kymo therapy and radio-isotopes. In addition refresher courses are given each morning at eight o'clock during the convention. The general program covers such topics and activities as a panel discussion o teaching methods, a talk by a representative of the examining board of the C.S.R.T. on the subject o preparing and giving examinations the "Welch Memorial" lecturers an awards, C.S.R.T. papers and award as well as varied lectures on de velopments in the field. Social ac tivities take place on June 17th i the form of a number of partie and a tour of Jasper and Banff.

A good storyteller is a perso who has a good memory and hopes other people haven't.—*Irvin S. Cobb*



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With the Auxiliaries

Musquodoboit Activities

A cook book has been compiled by the ladies' auxiliary of War Memorial Hospital, Musquodoboit Harbour, Nova Scotia. As well as a successful pantry sale held recently, a parcel post sale and marathon card party are organized by this auxiliary.

Gift for Sanatorium

The ladies auxiliary of the St-Laurent Sanatorium, Hull, Quebec, recently gave this hospital a billiard table with all accessories at the cost of $1,200. The providing of this popular recreational activity is made possible through the funds raised at the annual tea. The members of this auxiliary conduct therapy courses and also have furnished each sickroom with a bridge table and chairs.

B.C. Auxiliary

A new ice-making machine was recently donated to the Prince Rupert General Hospital, Prince Rupert, B.C., by its ladies' auxiliary. The machine produces 225 pounds of cubed ice per day and is one of the many gifts of this auxiliary which lately held its Jubilee coffee party, a source of proceeds for further equipment.

Linen Ball

The gaiety of Mardi Gras lent life to the Linen Ball of the ladies' auxiliary of Sherbrooke Hospital, Sherbrooke, Quebec. Proceeds go to the purchase of linens for the hospital. Large brightly coloured, glistening masks were used in the decoration of the rooms at the Hotel Sherbrooke as well as life size Mardi Gras figures. Masks were sold to the dancers during the evening.

Memorial Book

A memorial book bearing the names of those people in whose memory contributions have been made to the Port Colborne General Hospital, Port Colborne, Ontario, was dedicated at a service in the hospital chapel in March. The book was presented by the women's auxiliary.

Air-conditioning Units

Patients in the Northwestern General Hospital, Toronto, Ontario, in the near future will find air conditioning for their comfort thanks to the ladies' auxiliary who recently presented a cheque for $3,500 to the chairman of the board of governors of the hospital to supply this need.

Montreal Auxiliary

At the annual meeting held in March of the women's auxiliary of the Montreal Children's Hospital, Montreal, Quebec, the president presented a cheque to Dr. Robert Ingram, executive director, for $12,500 for research and equipment. She also gave a cheque for $3,000 to Dr. Alan Ross, physician-in-chief, for medical research.

Wing Furnished

The recently opened Scarborough General Hospital has a brightly furnished nursery due to the efforts of the women's auxiliary who raised over $10,000 for this project.

Busy Auxiliary at Pouce Coup

The women's auxiliary of the Pouce Coup Community Hospital, Pouce Coup, B.C., hold a bridge bonspiel in which members have bridge parties in their homes with the winners playing off for prizes as in a regular bonspiel. Recent equipment provided the hospital by these ladies includes a new isolette incubator.

Manitoba Auxiliary

The ladies' auxiliary to Misericordia General Hospital, Winnipeg, Manitoba, made a donation of $3,965 for hospital equipment at the annual meeting in March. This equipment will include neurological instruments, operating table accessories, rehabilitation and post operative apparatus, a Stryker orthopaedic frame and six nursery chairs. Best money-raising projects were the gift shop and cart and the television set rentals and baby pictures.

A new project for the auxiliary is sponsoring the teaching of crafts to patients in the psychiatric ward.

Honorary Officer

Mrs. W. C. Mikel of Belleville, Ontario, a former vice-president of the Ontario Hospital Auxiliaries and one of the Honorary Officers died at her home in February. She presided over the convention i 1952.

Annual Party for Hospital Birthda

Every year for 47 years th women's auxiliary of Bowmanvil Memorial Hospital, Bowmanvill Ontario, has held a birthday par for the hospital since it opened i 1913. In the first years gues came from far and near bearin gifts of all kinds — fruit, veg tables, linen, — anything the ho pital could use. In 1934 a comin of-age party was held with birt day cake and all the trimmin with such success that it has bee conducted along these lines ev since. Through the years the ty of donation has changed to le and less produce and linen an more and more money. The part this year was held in March.

At the Toronto East General

A five year pledge of $25,00 obtained in only three years is t the credit of the women's auxiliar of the Toronto East General an Orthopaedic Hospital, Toronto, Ontario. Ninety volunteers spen 9,600 hours in the gift shop and ninety more gave 7,000 hours of service in the hospital.

B.C. Convention

The dates for the annual convention of the B.C. Hospital Auxiliaries to be held this year in conjunction with the Western Canada Institute are September 7, 8 and 9, in Vancouver at the new Queen Elizabeth Auditorium. The theme for the gathering will be "Setting our Sights on the 60's".

New Equipment at Oliver

Another new piece of equipment has been added to the expanding facilities of St. Martin's Hospital, Oliver, B.C. It is a BMR machine used for metabolism tests. The Osoyoos auxiliary was instrumental in this purchase. Through different projects they collected $530 for this equipment of which the government will pay one-third.

Electric Bed for Montreal General

The women's auxiliary of the Montreal General Hospital has presented a circular electric bed to the hospital through funds raised by the "hospitality corner". The bed will be used to help paraplegics and victims of polio or strokes to learn to stand upright again.

Medicine: the only profession that labours incessantly to destroy the reason for its own existence.

James Bryce

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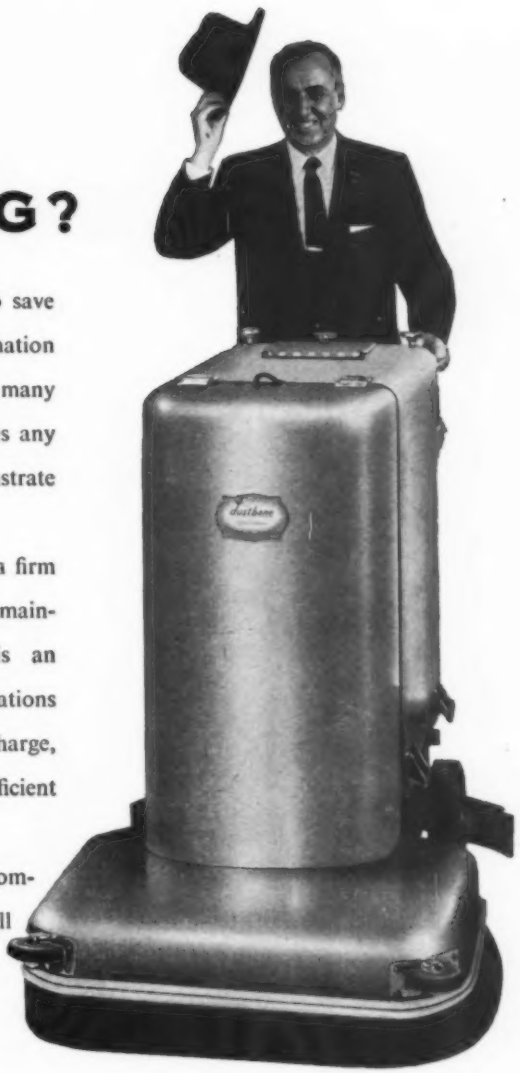

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C.S.R.T. Story

PRIOR to the formation of the Canadian Society of Radiological Technicians in 1943 there were no generally accepted standards of technician training. Some provinces set their own qualifying examinations and in others technicians registered with the American Society of X-Ray Technicians, a body established in 1920. The important events for the period 1943-1959 when more and more attention was being paid to technician training in Canada are outlined in the following.

In 1943, The Canadian Society of Radiological Technicians was established by a federal charter with the Central and Provincial Examining Boards appointed by the C.S.R.T. The year 1944 saw the Provincial Boards dissolved and one standard examination set by the Central Examining Board (Committee on Qualifications) leading to the granting of the "R.T." certificate in Diagnostic Radiography and Radiotherapy.

In the next two years a C.S.R.T. syllabus of training was published and a C.S.R.T. Committee on technicians' training established to study current training and make recommendations.

In 1948 the Canadian Association of Radiologists' Standing Committee on Technicians was established on the recommendation of the chairman of the C.S.R.T. Its purpose lay in drawing up a detailed curriculum and in acting as a liaison between the C.A.R. and the C.S.R.T. Following this in 1950 the C.A.R. Instructors' Curriculum in Radiological Technique was adopted by the C.S.R.T. and the next year it was published jointly by the C.A.R. and the C.S.R.T.

In 1955 a separation of training and examinations for Diagnostic and Therapeutic Technique was proposed, agreed upon, and the necessary revisions were begun. The C.A.R. Committee on Technicians and the C.S.R.T. Committee on Technical Training were also amalgamated to form the Joint Committee on Technical Training with the object of formulating a plan for setting up approved schools. Two years later the minimal requirements for Approved Schools and the proposed plan for establishing approved schools were presented by the J.C.T.T. to their association. A separate syllabus as well for training in Radiotherapeutic Technique was adopted and published jointly by the C.A.R. and the C.S.R.T. at this time.

May of 1958 saw the first separate examinations held in Radiotherapeutic Technique (R.T.(T).). The Joint Committee on Technical Training became the Joint Council on Technical Training, C.S.R.T. and C.A.R., with the status of a special committee of the two Associations. In June of that year authorization was given to the J.C.T.T. to act as the official agent of the C.S.R.T. and the C.A.R. for "Approval and Accreditation of Training Schools". Questionnaires and invitations to apply for approval of schools in either Diagnostic or Radiotherapeutic Technique issued by the J.C.T.T. were put out in August. Then in December, the Canadian Medical Association was approached by the C.A.R. at the request of the J.C.T.T. with a view to undertaking the accreditation of such school.

Following this in January, 195[illegible] the revised Syllabus in Radiographic Technology was publish[illegible] jointly again by the C.A.R. and t[illegible] C.S.R.T. and the C.S.R.T. L[illegible] Books for Diagnostic or Radi[illegible] therapeutic Technique were intr[illegible] duced for student technicians [illegible] well. Finally in June a Standi[illegible] Committee of the Canadian Medic[illegible] Association on "Approval of Schoo[illegible] for the Training of Radiologic[illegible] Technicians" was established a[illegible] in November, 1959, publication [illegible] the J.C.T.T. list of official "Interi[illegible] Approved Training Schools [illegible] Diagnostic or Radiotherapeut[illegible] Technique" came about. A brochu[illegible] describing the basic requiremen[illegible] and minimum standards which mu[illegible] be met by hospital schools for a[illegible] proval by the above C.M.A. Co[illegible] mittee is now being distributed t[illegible] gether with an application for[illegible] for approval.

Twenty Years Ago

From "Canadian Hospital", May, 1940

M.S. "Columbia" on Patrol

For thirty years the stalwart "Columbia", the hospital ship of the Columbia Coast Mission, has made her way up and down the British Columbia coast. Last year her mileage on medical patrol was 17,034, and of this 3,874 miles were travelled in answer to radio "S.O.S." calls. Dr. Gordon Worsley, the ship doctor, saw 436 patients in their homes, and 446 patients came to the ship's dispensary for consultation or treatment. St. George's Hospital at Alert Bay, two hundred miles up the coast from Vancouver, is the home port of the "Columbia" and she reports there once a week, when surgical cases are cared for.

* * *

From Costume to Custom

An interesting story is told of the development of the nurse's uniform on this continent. It is said that in the early years of the training school at Bellevue Hospital in New York City the authorities were quite anxious to have a uniform for the nurses, but that the nurses themselves were opposed to it. The deadlock was broken very happily. One of the best looking girls in the school, a certain Euphemia Van Rensselaer, who was also a member of the inner circle of New York society, was approached by 'the heads'. Euphemia went home for a couple of days, consorted with the family dressmaker and returned resplendent in blue and white seersucker with white apron, collar, cuffs and cap. It took the school by storm and in no time at all every girl in the school had blossomed forth in the uniform.

* * *

Municipal Clinic of Radiology Opened in Montreal

A clinic of radiology has been opened by the city at the Laurier Health Centre. This clinic is for diagnosis only and is intended for the suspected case of tuberculosis or contact who cannot afford a radiograph or does not want to go to an existing anti-tuberculous institution. Patients may be referred to the clinic by the family physician who will be sent a confidential report on the films taken. No treatment will be given. The Clinic will be open to the public during week days, except for Saturday afternoon, and on Tuesday evenings.

Powassan Virus Traced

Powassan virus, a form of deadly encephalitis, has been traced to ticks carried by squirrels, chipmunks and rabbits. Dr. D. M. McLean, virologist at the Hospital for Sick Children, Toronto, said that northern Ontario residents should avoid handling these animals until a vaccine is found to protect them. He is conducting research on the virus in the Sudbury and Manitoulin areas.—*The Globe and Mail.*

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(continued from page 38)

Moving patients is easier today. A car can travel faster than a horse and a helicopter faster than a dog-team. Our world has become more technical and more specialized. Communications have improved and so have methods of diagnosis and technical procedures improved in the same way by complexity and a discipline of order. It needs a good deal of discriminating judgment to use the available social and technological advances to provide in your hospital what is best for the patients to whom you are responsible.

It cannot be repeated too often that a hospital is people. The training and experience of people which gives them competence is always more important than the technical things they use. Certain tools are essential but owning a Ferrari does not make one a Sterling Moss, nor does owning an electrocardiograph machine make one a cardiologist.

What is your responsibility in this area and how may you meet the challenge of this responsibility to provide a hospital of the type your community needs in terms of the three aspects mentioned, type of beds, type of service to be rendered, and available resources of staff? I suggest that you think over the question "What is the hospital community?" The world has not only become more scientific, giving us more tools and skills for better patient care, it has shrunk, bringing them closer to us. Neighbours are closer than they used to be. Communities formerly isolated are isolated no longer. The hospital should not then be considered in isolation. Its type, services and resources should be considered in terms of neighbouring hospitals' type of services and resources. And the neighbouring hospital may not be 20 miles away. It may be that only one 200 miles away can provide a certain service. The hospital community is bigger than you think.

There is no standard pattern of over-all planning which will be suitable for any particular geographic area. I am sure, however, that if trustees would start to think of their community in the larger setting they could better solve some of their problems. I am sure that unless we start to do some serious thinking about this and plan and develop accordingly, someone else will feel the compulsion to do it for us.

There are two principles which should be kept in mind in such planning. First (emergencies excepted) nothing should be attempted or done in any hospital unless there are the equipment and skills available to do it with competence. The second principle, the converse, is that all the technical things and skills in the community should be available for a high quality of patient care. Thinking of your hospital community in the larger concept will greatly increase the potential of resources available to it.

Administration

It is the board's responsibility also to appoint a competent administrator and require competent administration. There is a failure in some quarters still to recognize that hospital administration is a profession for which adequate formal training is required and one which demands a high degree of intelligence and ability in management. Too often this extremely demanding and extremely technical job is entrusted to untrained people. The value of the trained administrator has yet to be recognized by some boards and some medical staffs. It is the responsibility of the board, not only from the point of view of economical operation but in the interest of good patient care, to secure an administrator with adequate training, experience and competence commensurate with the demands of the job.

In many hospitals the administrator has too few good text books and journals appropriate to his job. Some have not even the basic text book, MacEachern's *Hospital Organization and Management* which is generally regarded as the hospital administrator's bible. The hospital administrator needs tools to do his job too.

There is also a misconception, far too prevalent, that management of a hospital is divided responsibility, split between the administration and the medical staff. It should not be. No company can function with two boards of management. There is one authority—the board. You would not permit the suggestion that in your industry there be divided authority between administration and sales or between administration and production. Administration is there to plan, organize and direct for both sales and production. In the hospital it is there for the medical staff and for the nursery and for dietary and all the other multitudinous services that make up modern patient care. But the board, while responsible for over-all management must not interfere with administration. You would not think of telling a surgeon how to perform an operation, a medical records librarian how to code a diagnosis or a dietitian how to compound a low cholesterol diet, even though you have the constant responsibility to ensure that proper surgery is performed, proper coding is done and proper diets prepared. Neither should you interfere in personnel or purchases or stores or housekeeping. The administrator is responsible to you for these things. The meddling trustee is an irresponsible trustee. The interested trustee will be less tempted to meddle if he has a competent administrator. But while the trustee should not interfere, he must, as a board member, ensure that administration is effective. With a good board of governors, an able administrator and an organized and competent medical staff, and with proper liaison among them, the efforts of all can be directed to the primary objective, high quality care for the patients.

Standards of Patient Care

It is the board's responsibility to determine the standards of patient care. There is the misconception that this is the sole responsibility of the medical staff and the concomitant misconception that the board, consisting of laymen, is not competent to assume this responsibility. Now I, as a physician, would be the first to declare that lay members of a hospital's governing board are not competent to judge the *quality* of medical care but let there be no question that the board has both the ability and the authority to dictate the standard of care to be provided.

How can a board of non-medical members determine what the adequate standards of patient care for their hospital are and whether those standards are being met? They do not have to look far. The Canadian Council on Hospital Accreditation provides standards. The standards are not new and they are basic. If a hospital has a certificate of accreditation, the board has assurance that minimum standards are being met and further, that periodic review of the conduct of the hospital will continue to be made, followed by recommendations for still further

(continued on page 84)

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Trusteeship

(continued from page 82)

improvement of the quality of patient care. I need not further elaborate on this subject, but repeat only that the standard of patient care is a trustee responsibility.

Medical Staff

The board is responsible for appointing the medical staff and ensuring that each physician is qualified and competent to carry out the procedures he is permitted to undertake in the hospital. There is a misconception in many places that this is the responsibility of the medical staff. It is certainly a heavy responsibility of the staff by delegation, but it is both primarily and ultimately a responsibility of the board. It is stated in the *Standards* in these words: "the governing body of the hospital must obviously delegate the responsibility of medical functions to the medical staff, including recommendations as to the professional qualifications of all who practise in the hospital" and "the medical staff is responsible to the patient and the governing body of the hospital for the quality of medical care rendered to patients in the hospital". The medical staff is responsible to the board. The medical staff makes recommendations to the board but it is the board which must make the appointments because the board is legally responsible for doing so.

I would refer you to an address given by Dr. Frederick Evis, a physician, lawyer and medico-legal consultant to the Ontario Hospital Services Commission, before the Ontario Hospital Association convention in October 1957. The address was reprinted in the July to October 1958 issues of *Canadian Hospital*. Dr. Evis points out that court rulings have unquestionably established that the hospital board of governors, by virtue of its responsibility for government and management of the hospital, has full responsibility for hospital operation and full authority over hospital personnel, including its medical staff; that it has the right to require every applicant physician to submit evidence of his credentials; that it has the right to appoint physicians to the staff and grant privileges accordingly, and the right to refuse medical staff privileges and to withdraw privileges previously granted to any physician who does not satisfy legal requirements which the board is entitled to make.

These powers are not only rights, they are duties of the board of trustees. The board is responsible and can be held liable for not having exercised due care if it permits physicians to admit or treat patients in the hospital unless the physicians have been properly appointed and their privileges properly allocated.

Both Dr. Evis and Dr. McEachern (in the book previously referred to) are careful to draw attention to the fact that a licence to practise medicine does not *per se* give a physician the privilege of admitting his patients to a hospital or grant him use of the hospital's facilities or equipment. The hospital appointment is a privilege and not a right. Both also specifically refer to the number of court cases which have upheld the principle that it is not considered illegal discrimination if, from a number of physicians in an area, a hospital selects members of its medical staff with regard not only to their medical skill and knowledge but to their adaptability to the rules and discipline of the hospital.

Let us hear no more nonsense t en to the effect that every licensed p actitioner has a right to hospital s aff appointment, that privileges s ould be the same for all physic ans, or that every physician is e titled to use the hospital as he s es fit to treat his private patients. T e hospital is a community pro- j t and you are its trustees and g ardians. The medical advisory c mmittee of your medical staff a e your expert advisors. You are g eatly supported in fulfilling this p rticular responsibility by the c ncern of physicians themselves t guard their ancient prerogatives a d maintain discipline in their o n house by the traditional ethical p nciples of their profession. How- e er, the medical staff's interest a d sincere effort does not relieve y u, as hospital trustees, from the u timate responsibility of selecting m dical staff who are qualified and c mpetent and of assigning them p ivileges to perform certain pro- c dures. You would be presumptu- o s and vulnerable, of course, if y u undertook this without con- s ltation and advice from the m dical staff.

If you are to assume this responsibility properly, you must see to it that the by-laws of your hospital, and those of the medical staff, give adequate authority to permit you to perform this important function. Your hospital's by-laws are important if you are to avoid legal and medico-legal problems, as well as to ensure that there is good patient care. If you have good by-laws and a medical staff organized and functioning according to the *Standards* of the accreditation program, this responsibility can be assumed in an orderly way.

With special reference to the pattern for authority and responsibility for medical staff work, I refer you again to the *Standards*. Here are set out the principles and a pattern for effective control in the interest of high quality patient care. The medical staff should be self governing. Only by effective self government can they properly discharge their responsibility to the patient and to the governing body for the quality of all medical care rendered to all patients in the hospital and for the professional practices of all.

Summary

In one article, it is obviously impossible to discuss many trustee responsibilities. I have chosen to discuss five only: (a) responsibility for conduct of the hospital; (b) responsibility for the type of hospital provided; (c) responsibility for administration; (d) responsibility for standards of patient care; and (e) responsibility for appointment of medical staff. These five were chosen for discussion because they cause far too much misunderstanding.

I am happy to say that, in spite of the pressure of continually increasing hospital usage, there is every evidence of growing public confidence in the quality of hospital care being provided. This speaks well for the quality of trusteeship we have had under our voluntary hospital system. The great danger, as I see it, is for trustees to put their confidence in progress as though it were a thing in itself, and a good in itself, and so assume that the latest development is necessarily the best, expecting that advancing social legislation and

social trends, and increasing technology and specialism will eventually solve all their problems. Conversely and paradoxically, they permit themselves to become the victims of habit and tradition so that their concept of a hospital is fixed to a particular time and place. These are changing times and you must think constantly in terms of change.

One other thought. The board represents power. The board has power. Power is inherent in the concept of trusteeship. Trustees' decisions affect human lives because they direct human conduct. You can never exert your power with equality—you must do it with equity.

Trustee responsibility is an onerous responsibility, but it is one in which you can find deep satisfactions because "the more immanent the activity the higher the life." Trusteeship is a progressive personal activity. The trustee is called upon to grow with the responsibilities of his trusteeship, from the relatively simple acts of providing the equipment and skills for operation of the hospital to the mature process of relating these to ethical values in patient care. The hospital will grow in humanitarian service as its trustees grow in their assumption of responsibility in this sense. ■

Drop in Alcoholic Admission Rate

The Alcoholism Research Foundation has reported a drop in the number of alcoholics admitted to general hospitals in Toronto. A similar situation has been reported in Ottawa, Hamilton and London, Ontario.

A shortage of hospital space is believed to be partly responsible rather than any decline in the number of applicants. It is difficult to arrange admissions to these hospitals. Also hospital insurance has played some part in reducing the numbers admitted to general hospital through increasing demands on these hospitals for admissions of all types.

Dr. Armstrong, the foundation's medical director, predicted that there will be a big increase in the demand for treatment in the next few years. He said this may be precipitated in part by a recognition of a complex of symptoms identified as alcoholism or alcoho addiction and by pressure exerte by family, employer or court.

Recent studies have shown tha the present methods of estimatin the number of alcoholics in Ontari are inaccurate. The foundation trying to find a better way of tak ing a census. Current estimate are that Ontario has at least 80,00 alcoholics and that Canada has least 200,000. However it is be lieved the actual figures are highe

Kresge School of Nursing

In recognition of the $200,00 contribution made by the Kresg Foundation towards the $500,00 cost, the new school of nursing t be built on the upper campus o the University of Western Ontari will be named the Kresge Scho of Nursing.

The School of Nursing is no housed on the third floor of th Physical and Chemical Science Building in the space previousl occupied by the Department of G ology. The School has 146 student this year in courses leading to the Bachelor of Science degree in nurs ing, the Master of Science degree and diploma courses.

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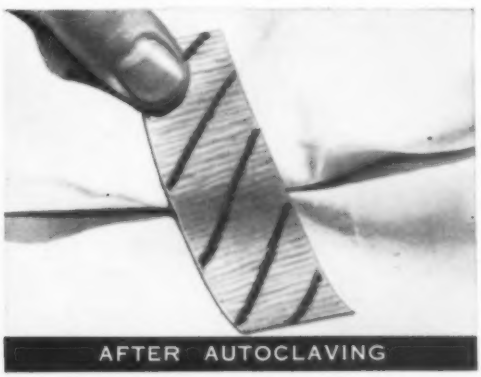

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Changing Concepts

(continued from page 49)

expediture and other services, community-, province-, and nation-wise that we are undergoing in North America at the present time. Since new discoveries are bound to continue in the medical field, we may expect that this problem, too, will be a continuing one.

For example, if 40 years ago a survey of 10,000 people revealed that 50 children had a congenital malformation of the heart, there was very little that medicine could do at that time to correct the situation. However, if to-day out of a survey of the same sized group there were an equal number of children suffering from the same ailment, we fortunately would be able to do something about the condition for most of the cases. If, because of the expense involved, it is found that of the 50 patients only five of the children come from families who can afford to pay for the operation, we are then faced with a decision as to the future of the other 45 children. Assume that the five families who can afford the treatment make the necessary arrangements and have the operation carried out. However, because the other 45 are not able to meet this expense, society is not prepared to let the matter stand; and arranges to have the other 45 children admitted to hospital when the operation is performed. The problem now facing us is the financing of the 45 heart operations. Will this expense be met by way of voluntary contributions collected by charity drives; by contributions from industry; by the doctors and the hospitals providing the service without charge; or will it be met by some form of government support such as the granting of funds to cover the expense, or a form of governmental coverage program? There are many ways in which the expenditure can be met, but the point is that nowadays the care will be provided and must be paid for in one way or another.

In Canada, with the passing of the federal-provincial hospital plan, we have decided that the demands of the consumer public, insofar as hospital care is concerned, will be met, for the most part, through the channels of government in co-operation with the community hospitals. Therefore, it is logical to expect that governments will have a considerable amount to say about the expenditure of public funds for hospital care, even though the services are provided by independent hospital societies which are not part of the government service.

In the future, there is no doubt that medicine will continue to advance and keep pace with other sciences. Developments in space travel will undoubtedly be paralleled in the medical field, but as these new medical care services are brought to the people it will likely mean new equipment, new techniques and higher costs. One has but to review the use of isotopes in nuclear medical programs to appreciate what has been done in the past decade and the effect that programs in this field have had and will continue to have on hospital and medical care.

A Question

The question has been asked as to whether or not society will allow medical care to lag behind other fields. The answer has been a resounding "NO". The people have already shown that they expect the newest cures to be made available to them.

(concluded on page 92)

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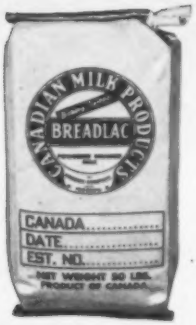

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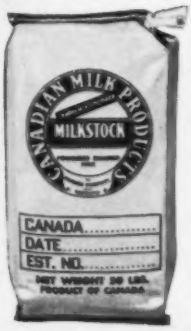

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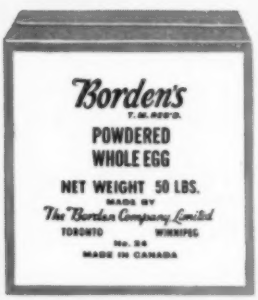

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Changing Concepts

(concluded from page 90)

In Canada we have decided t meet this situation in the hospit field through the implementatio of governmental hospital plan which, in turn, bring new problem involving the prepaying third part agency of government. One of th great challenges facing the medic and hospital professions is the pr senting of their case for bett medical and hospital care to th consumer public so that the peop in turn will better understand th professional problems in these fiel and, after considering the issu involved, decide on the proportio of the economy that should b spent on medical care. ■

Accreditation

(concluded from page 40)

who extol the virtues of the we have a challenge before us.

Insecurity engendered by the fear that they cannot make the grade causes board or medical staff members to be apathetic, opposed or hopeless in their attitude towards accreditation. If we use the educational approach and tell these people what accreditation is and what it is not, we should be able to dispel this fear and gain their support.

There is much more that might be said to illustrate the rôle of accreditation and thereby to demonstrate its great worth and practicability. Accreditation is more than practical; it is a necessity if a hospital board or medical staff wishes to be certain that good care is being offered to the community. To quote Dr. W. I. Taylor, Director of the Canadian Council on Hospital Accreditation, "Accreditation is a hallmark. It is like the stamp 'sterling' on silver. Accreditation identifies the hospital that is offering its people at least a good minimal standard of care and is making a tangible effort to offer still better care."

* *Author's Note:* Since this paper was presented and submitted for publication, figures have become available up to December 31st 1959. The percentage of public general hospitals accredited in each of the three most westerly provinces has risen as follows:

B.C.	24 out of 71	33.8%
Alta.	20 out of 70	28.5%
Sask.	18 out of 54	33.3%

He who is disposed to ignore history must be prepared to repeat it.—*George Santayana.*

A.C.H.A. Activities

The Board of Regents has redefined some of the eligibility factors for admission to the College to accommodate an enlarged professional concept of the field of hospital administration.

This will be done by a more liberal interpretation by the Board of what constitutes an "acceptable" hospital. As newly defined, an "acceptable" hospital is one that is listed in the *Guide* issue of *Hospitals*, the journal of the American Hospital Association.

"A candidate will now be judged on his professional and personal qualifications rather than the accreditation status of his hospital", ACHA President Ray E. Brown said, commenting on the Board decision.

"The new ruling will give eligibility for admission to many administrators who formerly could not qualify because of the status of their hospitals", he added.

President Brown headed a special committee on the organizational structure of the College which made the recommendations for liberalizing the admission requirements to the Board.

Plans for implementing the new ruling are being formulated by the College's study committee on admissions and advancements. R. Z. Thomas, Jr., administrator of the Charlotte Memorial Hospital in North Carolina is chairman of that committee.

Suggest Officers Now

An appeal for all members of the College who have suggestions for candidates for the offices of president-elect, first vice-president and second vice-president to communicate with members of the nominating committee was made by Frank S. Groner, chairman of the committee and administrator of the Baptist Memorial Hospital in Memphis. Donald M. Cox, commissioner, British Columbia Hospital Insurance Service, Victoria, is the Canadian representative on the nominating committee.

Choose Site for Congress

The Morrison Hotel in Chicago has been selected for the second consecutive year as the site of the College-sponsored Congress on Administration, Dean Conley, executive director, has reported.

Mr. Conley said the Fourth Annual Congress on Administration would be held there February 2nd-4th, 1961.

ACHA Publishes 1960 Directory

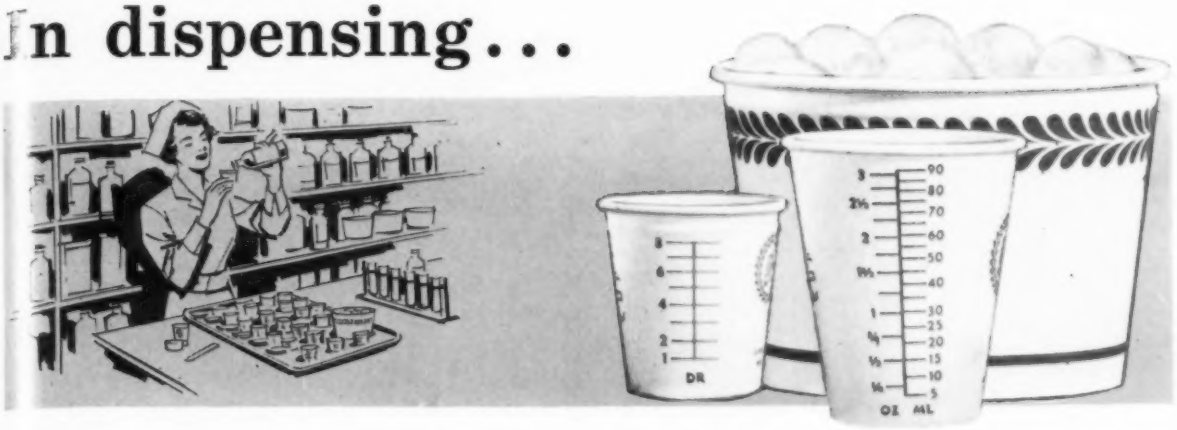
The 1960 Directory, published by the American College of Hospital Administrators, is the first comprehensive biographical dictionary of its entire membership to be compiled since 1948.

The directory contains detailed biographical data about all Honorary Fellows, Fellows, Members and Nominees of the College, an association of professional men and women whose life's work is in the field of hospital administration.

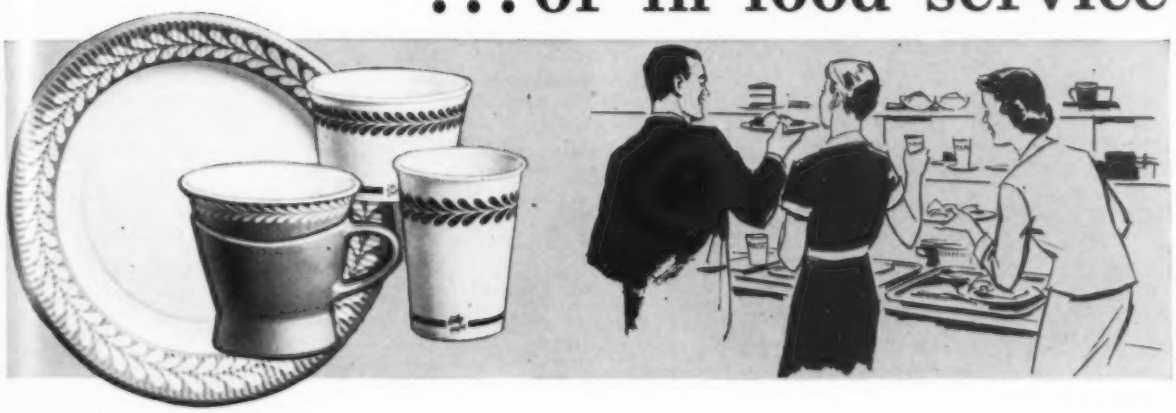
Data, both professional and personal, on all affiliates of the College were furnished by listee-members from comprehensive questionnaires developed by a specially appointed board of listings. Frank S. Groner, former president of the College and administrator of the Baptist Memorial Hospital in Memphis, is the chairman of this special board, which consists of one representative

(concluded on page 96)

In dispensing...



...or in food service



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A.C.H.A. Activities

(concluded from page 94)

appointed by the Regent of each of the society's regions.

There are three major sections in the 1960 Directory: an introductory section containing descriptive information on the College and its membership and program, a middle and major section of alphabetically arranged biographical listings of the membership and a final section containing a classified regional index.

The 1960 Directory of the College sells for $15.00 and is available to institutions, health agencies and voluntary and commercial organizations serving the hospital field through the Publications Department of the American College of Hospital Administrators, 840 North Lake Shore Drive, Chicago 11, Illinois.

The 1960 Directory of the College contains over 3,800 biographical listings on 472 pages, bound in full blue cloth stamped in gold. The directory was typeset, printed (letterpress) and bound by the Bensen Printing Company of Nashville, Tenn.

The 31-page classified-regional index of the directory was reproduced by offset printing prepared expressly for the College by the Wilmotte Research Tabulating Inc. of Chicago.

This year, the 1960 Directory will replace the Roster, an annual publication of the College containing the names, addresses and classification of the membership.

Mental Health in Canada

In the last decade, the Canadian Mental Health Association has increased its membership from about 70 to well over 100,000 and has no less than 115 separate branches in different parts of the country. The Canadian Association for Retarded Children — established only two years ago — now boasts a membership of some 12,000 active workers in 118 local branches across Canada. And besides these groups there are numerous local organizations working in the field of rehabilitation and on behalf of emotionally disturbed children. All of this is purely voluntary effort and indicates the mounting importance which individual Canadians are attaching to the conquest of mental illness and the promotion of mental health. —*Hon. J. Waldo Monteith*

Toward Better Patient Care

(concluded from page 51)

tend this meeting. As a result of this session many recommendations were directed to the hospital administration. The workshop was concluded by a dinner organized by the social convener.

There are many signs that the workshop has had immediate effects. Although many of the recommendations have not as yet been implemented, the knowledge that we are not alone with our problems has resulted in a better understanding of each other, and has made us aware of the need for continual nursing evaluation. Another obvious result is the closer understanding that has been created between clinical instructors and head nurses. These two groups are planning to hold regular meetings for the purpose of discussion and attempting to solve problems together.

It was unanimously decided that a post workshop meeting will be held in May in order to assess the value of the workshop in terms of progress that has been made toward promoting "Better Patient Care". —*From a report by the Workshop Planning Committee.*

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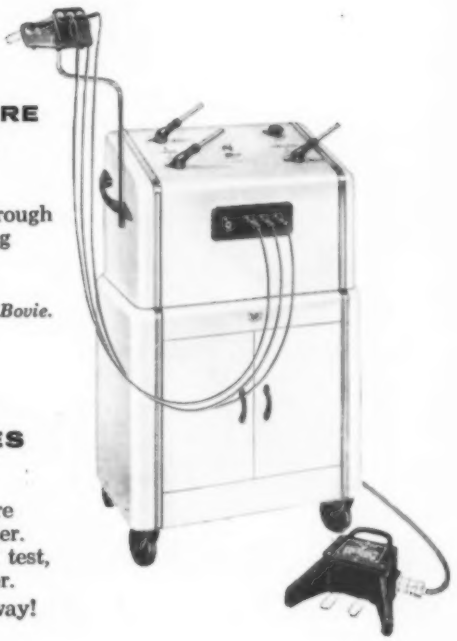

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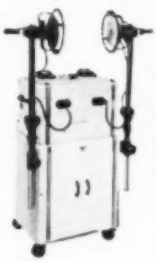

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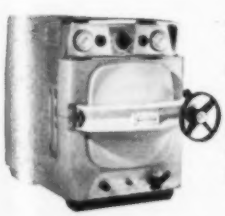

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Ask the Patient

(continued from page 58)

from July 1958, it was found th the number of suggestions in t second six months was considerab smaller than in the previous s months. This by no means is suggest that all faults have be corrected leaving nothing to cri cize. Nevertheless, it is encoura ing to see that suggestions ma by patients which were remed have been corrected so that the is little or no mention of certa items in later returns.

In some areas it was found th the same comments were repeat throughout the whole year. The are comments such as requests f menus by ward patients, insufficie bathroom facilities on the ward a too much noise.

Physical facilities and maintenanc

The main criticism was the shortage of bathroom facilities on the wards. A few patients commented that the bathrooms were poorly ventilated and that there was need for shelves in the bathroom for "peri" care. Other suggestions were:

1. Installation of shower facilities. (These comments came mainly from men).
2. Buzzer in the bathroom.
3. A swivel light for reading was mentioned a couple of times with others merely stating that there was no reading light or that the light was insufficient to read by.
4. A lack of dayrooms.
5. A need for an easy chair in the room for the ambulatory patient.

Dietary

Food is a subject on which everyone believes himself to be a connoisseur. In spite of this, the dietary department has received a large number of very favourable comments. Of course, there were the few outright complaints which are to be expected.

The most usual complaint in this department was the desire of ward patients for a selective menu. This comment has appeared consistantly throughout the 12 months. Creamed food was a frequent complaint in the first six months but since then has only occurred twice. On March 31, 1959, there was a complaint about cracked dishes, but this has not reoccurred. Another frequent suggestion was the desire for a light lunch in the evening. Other comments were: use of serrated knives; toothpicks at meals; and more fresh fruit in season. Some of these adverse comments about

food were from people on special diets. A good many of these people did not fully understand the reason for such food.

Staff, Visitors and Noise

The friendly, courteous and efficient attitude of the staff were reflected in the numerous compliments rendered to them in the patient comment forms.

Most of the constructive criticism involving the staff revolved around the need for more staff, especially during the 3 p.m. to 11 p.m. shift. While some patients referred only to the shortage of staff in general, the majority referred to nurses and nurses' assistants.

In the earlier comment forms a frequent comment was the shortage of orderlies. Since the orderly complement has increased from 11 to 16 there has been a decrease in such comments.

The comments concerning visitors were relatively few with some patients desiring more visiting hours, while others wanted fewer visitors. Most of the complaints were of visitors smoking.

Noise was one of the major criticisms throughout the year. Noise to a sick patient is much more irritating than to the person who is well, so that it is important to keep noise to a minimum. Such complaints concerned: transportation of portable equipment; flushing toilets and running taps; noisy wheelchairs; loud radios; noise from utility rooms; rattling draw curtains; scraping chairs; noisy laundry carts; and slamming of bathroom doors.

Although the patient comment forms have obviously taken the time and effort of everyone concerned, it is felt that they have been worthwhile for a number of reasons:

1. The hospital staff is made aware of the problem and hence can take steps to correct the situation.

2. The staff is made aware of patient misunderstandings and therefore can clarify the misunderstanding with the patient.

3. It acts as a prod to keep the staff "on their toes."

4. The comment form acts as a good public relations medium. This gives the patient an opportunity to air his complaints whether they are justified or not and so leaves a more satisfied patient.

As a result of the most recent survey of the patient comments, the hospital has launched an anti-noise campaign. The committee set up to carry out this campaign has used such tools as printed fluorescent "Quiet Please" signs throughout the hospital, reviewed and acted on noisy equipment, and has publicized in the local newspaper the importance of being quiet in and around the hospital.

If you feel that your hospital is perhaps not a Utopia, at least from the patient's viewpoint, it may be desirable to implement such a tool to elicit the opinions of the patient. It is the patient we are concerned about, the patient we are striving to please, and the patient who is in the best position to comment on the hospital care he has received. ■

The mother of a 5-year-old boy told a psychiatrist: "I don't know whether or not he feels insecure, but everybody else in our neighbourhood sure does."

The AMA News

fore set at 64. In line with the above nursing hour provision, it was decided to have a full-time nursing staff of 32 on duty each day. This would provide 8, 5, and 3 on duty in each unit on each of the day, evening and night shifts respectively. A simple guide was drawn up indicating the number of relief workers to be added or reduced as the census fluctuated above the average. This called for an increase of one nurse for every addition of two patients and vice versa. If the count dropped below the average, the full-time staff would be providing more than four nursing hour service per patient day unless we happened to be short staffed for any reason whatsoever.

The full-time nursing staff objective was set at 42 to satisfy the weekly requirement and it was to consist of 50 per cent graduate nurses and 50 per cent of the various categories of nursing assistants.

Our experience during the course of 48 weeks was graphically recorded. The information required to draw this graph was the total patient days for each two week period and since the plan was to provide four nursing hours per patient day and nursing shifts are of eight hour duration the only other information required was the actual number of shifts worked on each period. The average percentage of occupancy during the recorded period was around 67 per cent, therefore occupancy which results from the natural day to day demand for service was in no way affected by lack of facilities.

In the illustrated graph, *line* traces the total patient days for each two week period. *Line B* records the number of nursing shifts which should have been worked to provide a four-nursing-hour service. *Line C* shows the actual shifts worked by the nursing staff in each period. The straight lines averages for each are marked *AA*, *AB* and *AC* respectively.

Glancing over the patient day line it is interesting to note how extensively our patient load fluctuated over the 24 periods, and that extreme peak periods were followed without exception by corresponding low periods of occupancy. Occupancy would otherwise be in the neighbourhood of the straight line average for several periods.

From the standpoint of achieving our objective of fluctuating the total number on nursing staff to correspond with patient load, the result indicates success to a large degree. The first eight periods show corresponding fluctuations. During this time full use was made of all available relief workers but the full time staff was below our requirement. The patient load for the following sixteen periods was in the neighbourhood of the straight line average except for three periods. The full time staff situation had improved and the staffing objective was very close except for a shortage during the one extreme peak of high occupancy. Our nursing hour service during this short period as well as the first eight periods was below the planned four per patient day. Slight variations from plan is accounted for by the fact that staffing arrangements must be made several days in advance and it is therefore difficult to adjust on a day-to-day basis.

The over-all figures for the 48 weeks show an average of 97

patient days per period. This was 77 above the estimated and expected average. The average number of shifts which should have been worked was 486 per period and the average number of shifts actually worked was 466. ■

Employee-Management

(concluded from page 46)

presentative. In addition the management representatives interpret management policy on certain problems. The ex-officio member, generally the personnel director, attends the meetings in an advisory capacity.

It must not be thought that all the worthwhile ideas and suggestions at the Winnipeg General Hospital are generated by the council members. Active participation of all employees is encouraged by means of suggestion boxes.

A rather novel feature of the Winnipeg General Hospital E.M.-A.C. is its "Nudge" committee. It is the function of this committee to ensure that the management makes adequate comment on the various suggestions and ideas.

The most important factor which maintains the vitality of participative management is increased mutual understanding and confidence. Unless management and labour are aware of the problems which the other faces there can be nothing but suspicion and distrust. A policy of "no-holds-barred", a carefully planned system, and a good publicity program certainly help in making the system successful.

Success of the Council System

The employee-management advisory council has been in existence at the Winnipeg General Hospital since February 1958. Since that time it has achieved a tremendous success in creating a mutual understanding and employee satisfaction. But this has not been its only achievement. We have found it a form of positive management resulting in improved patient care which after all is the aim of every hospital.

Superannuation Program

A superannuation program for B.C. hospital employees is expected to cost the government $1,000,000 in its first year of operation. It is intended that the program cover all permanent employees and provide a uniform standard of benefits. Participation will be voluntary.

Canadian Hospital

The Canadian Hospital is published monthly by the Canadian Hospital Association as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada, U.S.A., and Great Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscription for individuals directly associated wth them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies when available, are supplied at 50c each.

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Disposables

(concluded from page 45)

would be sheer speculation. Hospitals in Canada have always been conservative and possibly slower to adopt disposables than their American counterparts but it is reasonable to assume that many of today's disposables will be accepted for specific and individual application in the hospital. Their contribution to patient care cannot be discounted and it is quite possible that they may eventually provide a partial solution to the labour problems faced by hospitals today. ■

Job Evaluation

(concluded from page 54)

to pay fair and equitable wage rates is no longer valid. Administrators are finding that their employees, their boards of directors, and the public have not been slow to recognize this new situation. Pressures for improved working conditions are increasing and it seems only proper that the administrator be in a position to fairly evaluate these recommendations and demands. Job evaluation consisting of job analysis, job description, job classification and job pricing, is a tool which has been developed for just this purpose. ■

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College of Nursing

At the annual meeting of the R.A.N.O. in April it was decided that a College of Nursing is to be established with a government charter and that an Ontario Nursing School Foundation is to be set up to assist with financing of nurse education. To the proposed college would be given the statutory powers necessary for the determining and control of nursing standards of education and practices.

Volunteers

It has recently been announced that the North York Chapter of the Canadian Mental Health Association has begun recruiting volunteers for work in mental hospitals. This is a pilot project and it is hoped that it will be greatly expanded as important work in planning the social-recreational program.

Financial Assistance in N.B.

The Hon. Dr. J. F. McInerney, Chairman of the Hospital Services Commission of N.B., has announced that assistance for payment of past capital debts is being expanded to include hospital equipment purchased prior to July 1, 1959. In addition, hospitals of the province will be reimbursed in full for equipment purchases made after July 1 with the approval of the Commission.

Assistance from the province towards the retirement of capital debts will now cover two-thirds of the total indebtedness including equipment debt in addition to buildings, with the exception of buildings used as nurses' residences. The calculation of the annual capital debt assistance will be on the basis of a 40-year period, and will include the actual annual interest charges.

Medical Technology

The Royal Inland Hospital in Kamloops, B.C., is sponsoring the Third Annual Post Graduate Course in Medical Technology on June 1, 2, and 3. The purpose is to present basic, fundamental problems and principles of medical technology, primarily for the benefit of technologists in the smaller hospitals in B.C. and Alberta, but not excluding those in larger hospitals. Dr. Jack E. Newell of the University Hospital, Saskatoon, and Dr. C. J. Coady of the Royal Columbian Hospital will be principal guest speakers.

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Five Days in a Hospital

Staying in a hospital for five days, despite the many visitors and phone calls, gives one time to think. This is a good thing in itself. You think of unimportant things like the cost of hospitalization, and you realize why it costs so much. The service is wonderful, the meals equally so, and that is the way it should be. To provide such service there was someone to make our bed, another to help us wash, a third to take our temperature and pulse, a graduate nurse to give us our pills, a Sister supervisor who came to see that all the others had done their jobs, and a specialist to take our electro-cardiograph. Later we had specialists who took blood tests and of course the x-rays. Now we know why it takes money to operate a hospital and consequently why it costs money to stay in one.

But the service and food were wonderful. One fat-free meal which we enjoyed included: peaches, pears, prunes, grapes, bananas, oranges, apples, jello, pineapple, apple jelly, dry toast, tea without cream, and eight pills during the meal to prepare us for x-rays the following day. However besides the meals and service you think of many things — of light and open windows and the people who spend too much time looking into mirrors rather than out of windows. The cheerful hospital chaplain gave me something els to think about. It was he who said "Henry, you know a lot of peopl never look up until they're flat o their back." And how true that i Spending a few short days in th hospital has been an education t me. I'm sure I'd have been bett off and had a better outlook on li if I had had the experience yea ago.—*Taken from "Viney's Ve sion" by Henry Viney, a regul column on Calgary Albertan (Dail Sport's Page. This item appear July 19, 1959.*

Fund Raising Organizations

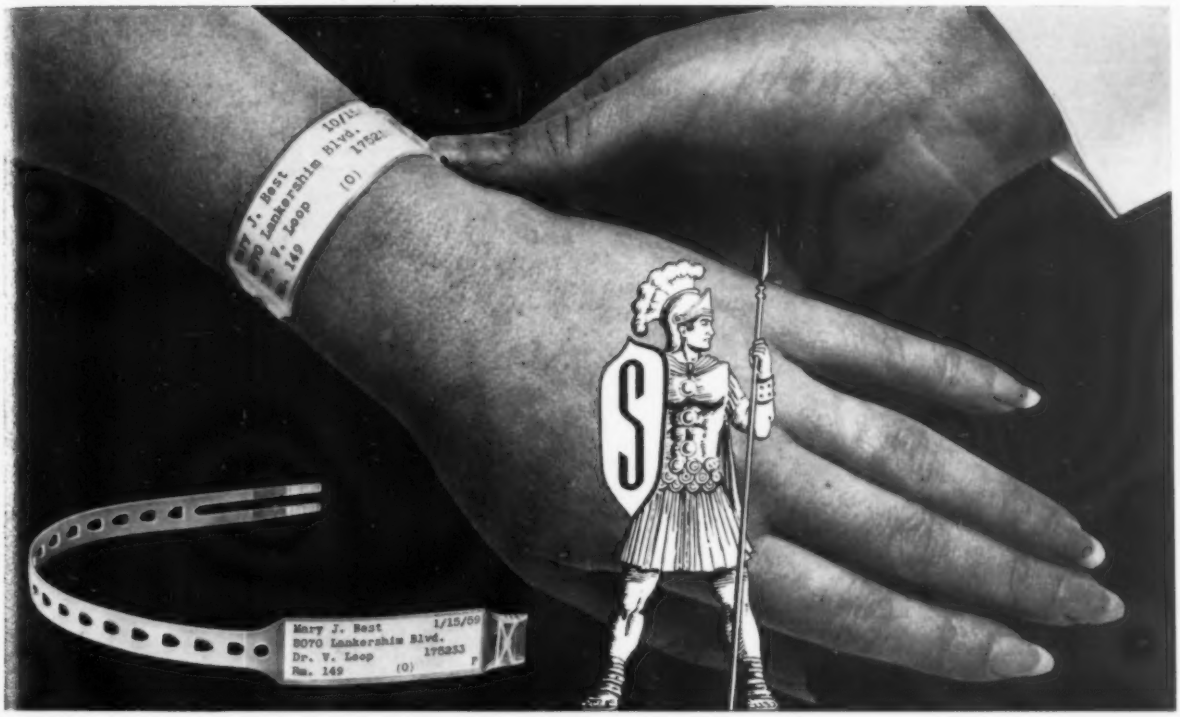
Territorial Insurance Plan

The Northwest Territories bega operating a hospital insurance ar diagnostic services program o April 1st, 1960. This was assure with the signing of a formal agre ment by the Hon. J. Waldo Mo teith, Minister of National Healt and Welfare, and Mr. R. G. Rober son, Commissioner of the North west Territories. The Agreemen is the tenth concluded under the Hospital Insurance and Diagnostic Services Act and brings to residents of the Territories benefits already available in nine provinces.

The Territorial Insurance Plan provides all in-patient services required under the federal act. These include hospital care at the standard ward level; necessary nursing services; drugs and related preparations including blood transfusions; routine surgical supplies; and laboratory, radiological and other diagnostic procedures together with necessary interpretations. The Territorial program also includes certain out-patient services when used for emergency diagnosis or treatment within a reasonable time after an accident.

Canadian Dietetic Association

The 25th National Convention of the Canadian Dietetic Association will be held June 14, 15 and 16 at the Queen Elizabeth Hotel, Montreal. Among the prominent speakers in the various fields of interest to dietitians and nutritionists are Dr. Hans Selye who will discuss "The Stress of Modern Living", Dr. Jean Webb who will speak on "Pre-Natal Nutrition", and Dr. Paul G. Weil on "Nutrition in Advancing Years". "Are Dietitians meeting the Needs of the Times" is the topic chosen by Dr. Géral LaSalle. Pierre Burton has accepted to give the memorial lecture, titled "The Klondike Gold Rush", which will be open to the public.



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Provincial Notes

(continued from page 72)

closed passages. The centre wing of three storeys and basement is approximately 233 feet by 62 feet joined by passages, at its north end to the kitchen and reception building, and at its south end to the administration building. The other two wings are similar in plan and comprise two storeys and basement, each wing measuring approximately 345 by 52 feet. Construction will be of reinforced concrete with red brick facing, matching the existing buildings.

A $2,000,000 addition is to be constructed at the Plummer Memorial Public Hospital, Sault Ste Marie. Plans call for an early start on the first two storeys of what will eventually become a five-storey hospital block with beds for some 300 patients. Government grants will provide about $750,000 of the total cost. The new addition will be joined to the existing hospital by a long corridor housing the administration offices of the hospital. Architects for the project are Rounthwaite and Fairfield, Toronto.

A hospital appeal for $2,700,000 opened this month for the new wing planned for the Oshawa General Hospital. Of this sum, $1,100,000 would be received in government grants. The Oshawa General Hospital Board recently received a request from the Institute of Eastern Medicine for blueprints and photographs of the Oshawa hospital with a view to building one like it in Karachi, in the Far East.

A $284,000 expansion project is planned for the Porcupine General Hospital, South Porcupine. Construction of a new wing on the east side of the hospital is expected to start soon. Extensive alterations to the existing building will also be carried out. The bed capacity will be increased from 22 beds to 49 beds.

Omission

In the April issue of this journal we published an illustrated article about Kipling Acres Home for the Aged in Toronto. Quite inadvertently the name of the architects who so kindly contributed the floor plans was omitted. Our apologies to Page and Steele, architects, 72 St. Clair Ave. West, Toronto 7.

A new $1,610,000 wing of the Scarborough General Hospital, Toronto, has been opened. The wing contains 165 beds, bringing the capacity of the hospital to 352 beds. A grant of $12,837.65 has been made to the hospital by the trustees of The Atkinson Charitable Foundation. The grant will be used to purchase special equipment for an intensive treatment centre. The 22-bed centre is part of the new wing.

Correction

In our March issue we published a note on construction at Hotel Dieu in Kingston which was, unfortunately, based on misinformation. It has been drawn to our attention that at that time plans had not yet been cleared by the Ontario Hospital Services Commission and so, of course, no general contract had been let.

Quebec

The Lakeshore Hospital Committee has decided that a community general hospital with an initial capacity of 150 beds should be established in the western part of the Island of Montreal and a site has been acquired west of Pointe Claire and north of Beaconsfield Golf Course. This has been based on recommendations made by hospital consultants Agnew, Peckham and Associates in their recent survey.

A committee to study ways of improving co-ordination and preventing over-lapping of effort among tuberculosis hospitals on the island of Montreal has been set up by the Royal Edward Laurentian Hospital, Montreal.

L'Hôpital Notre-Dame de Fatima at Ste Anne de la Pocatière is to receive a provincial grant of $1,250,000 toward the construction of a new building of 100 beds. It will be situated a few thousand feet to the east of the present hospital.

L'Hôpital St-Louis de Windsor Inc. is completing a new wing and renovating the old building to bring the bed capacity to 60.

New Brunswick

A new wing, with a capacity of 100 beds, will be added to Hotel-Dieu de L'Assomption, Moncton. Construction of the wing will get under way as soon as possible. Architects are at present working on plans.

The toughest form of mountain climbing is getting out of a rut.—*Journal of Phi Rho Sigma.*

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 25 Imperial St., Toronto 7, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge. ¼ page display advertisement — $25.00. Advertisements must be received by the first of the month to appear in that month's issue.

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Modern Hospital with 42 adult beds and 11 bassinets has vacancy for Director of Nursing.

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Salary according to qualifications and experience. Apply to Director of Nursing,

SUDBURY MEMORIAL HOSPITAL
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Experienced accountant to work for organization which gives assistance in statement interpretation and systems design for hospitals in western mountain state, U.S.A.

Travel involved. Salary commensurate with qualifications.

Send full information on experience and personal background to: Box 523 H, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.

Registered Medical Record Librarian

wanted, to supervise department in 160 bed hospital. Please apply to Administrator, Kirkland and District Hospital, Kirkland Lake, Ontario.

Staff Required

For present hospital with new 175 bed hospital under construction to open early in 1961

1 Pharmacist
1 Dietitian

Apply giving personal details, qualifications, training experience, names of three references and salary expected to:

Administrator,
YARMOUTH HOSPITAL,
Yarmouth, N.S.

Dietitian

Needed immediately. Main duties to include teaching of student nurses and some therapeutic diet work. 40-hour week, 10 statutory holidays, good salary. Apply to: Miss Mary E. O'Brien, Director of Dietetics, Royal Jubilee Hospital, Victoria, B.C.

Executive Director Required

We require an Executive Director with the following qualifications: a person with a Master's degree in hospital or in medical care administration. We operate a medical health plan and also two small hospitals.

Salary: $10,000 to $12,000 per annum, depending on qualifications and experience.

Apply in writing, giving full details to: Mr. Gordon Waldmo, Secretary, Board of Trustees, Hudson Bay Mining Employees' Health Association, P.O. Box 160, Flin Flon, Manitoba.

Position Required

Administrator or Business Manager. Good hospital experience, middle aged, conscientious. Please write to Box No. 534 M, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.

Classified Advertising

General Duty Nurses Wanted

For 30 bed hospital, reply stating experience and salary expected. Starting immediately. Reply to Secretary, Englehart and District Hospital Board, Englehart, Ont.

Hospitals Conduct Baby Sitting Course

As a community service to high school girls, some hospitals in Canada and the United States have initiated a course for teen-age baby sitters. In every instance the program has strengthened the partnership that exists between the community and its hospital. As well as assisting a teen-ager in assuming the responsibilities of baby tending, it has produced several volunteer workers for the hospital and recruited many of them to the nursing service.

One such course had filled its required enrolment of 77 two weeks before the course was due to start. This particular hospital conducted a five-week course which consisted of lectures by a child psychologist, the hospital's paediatrician, the obstetrical supervisor, the instructor in recreational therapy, and representatives of the police and fire departments. A variety of subjects were discussed including childhood fears and insecurity, diapering, feeding and bathing, children's diseases, and how to deal with prowlers and fire hazards. Graduation exercises were held at the completion of the course and all graduates were invited to participate as volunteer aides in the hospital's paediatric department.—*BCHIS Bulletin, October, 1959.*

Hotel Provides Out-Patient Accommodations

Out-of-town patients visiting Boston physicians or hospitals now are assured of hotel room accommodations at all times in one of the city's large hotels. This new service was started in March of last year.

A program of preferred room accommodations and therapeutic dietary control, at the physician's or hospital's request, benefits patient and out-patient visitors as well as the medical profession.

In working out plans for the new services, the program was handled in strict accordance with medical ethics. No public promotion was permitted at any time. The new type of service was announced in the *Massachusetts General Practice News*, the official publication of the Massachusetts Chapter, American Academy of General Practice. Reprints of this announcement were then mailed to Massachusetts physicians, along with an application for a physician's personal identity card. Since special room accommodations are available only on the request of the attending physicians or hospital medical director, these identity cards are serially numbered.

The hotel's own therapeutic dietitian directs the therapeutic dietary control. Sugar-free, salt-free, fat-free or specifically prescribed diets may be ordered through Special Room Service. Prices are the same as for the regular room service menu.

So far, the hotel management reports, interest in obtaining room reservations has been greater than in special diets. The majority of referrals and requests for accommodations came from clinics, rather than from individual physicians.

Clinics and private physicians have expressed their satisfaction with the new service as they no longer are faced with delay in booking patients during peak travel periods.

Physicians have used the preferred room accommodations service as an emergency measure and have extended many compliments to the hotel management for its public service attitude.

—*Hospital Topics*

New Dental Hospital

What is said to be the first hospital in the U.S.A. devoted exclusively to dentistry opened recently in Los Angeles. The $1,750,000 project will be the heart of a $4 million "Dental Square" that will provide dental health facilities in a "shopping centre" arrangement.

The new facility, to be known as the Southern California Dental Hospital, has 16 completely equipped operating rooms and dental equipment for all types of dental health needs. There are 30 recovery rooms and 50 patient rooms. The hospital's kitchen is equipped to prepare special diets required by patients. The completely air conditioned hospital includes laboratory and x-ray facilities. The medical records section is operated under punch card scheduling. A closed circuit television system for the convenience of the staff has been installed.—*American Hospital Association Journal, December, 1959.*

. . . Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

Southern Cross Central Supply And Laboratory Washer

Southern Cross is now offering to hospitals its latest model glassware and container washing machine, the Model 790. It is considered the most flexible and rapid washing machine designed to date for thorough volume cleaning of glassware, containers and metal ware.

Combining the best features of water jet machines with the rapid soil removal advantages of power driven spinning brushes, the all stainless steel Model 790 has a brush section with seven spinning vari-speed brushes and wet-brush-drill for instant removal of heavy soils. It is shipped with a complete kit of interchangeable brushes to handle pieces as small as 8mm tubes or 2cc syringes up to large containers such as 4 liter flasks or long cylinders.

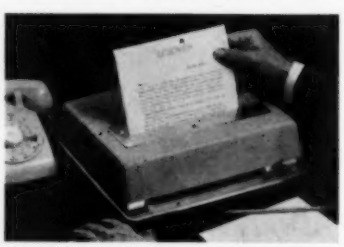
For removal of light soils, film, and for rinsing, there is a 24″ x 24″ jet compartment with three cycle operation to provide an automatic timed detergent wash, tap water and distilled (or demineralized) water rinse. Using heavy duty pumps and an entirely new jet principle, times as short as 30 seconds achieve perfect cleaning of an entire rack of glassware.

Precision built, and designed for a floor space as small as 30″ x 54″, the Model 790 washer will reduce washing time by over 50% according to all tests performed to date.

Write: The Southern Cross Manufacturing Corp., Chambersburg, Pennsylvania.

Handy Thermo-Fax Copying Machine for Desk Use

As handy as the telephone; as convenient as the typewriter. That's the petite, all-new "Courier" copying machine, newest member of the



"Thermo-Fax" brand copying products family. Designed and styled for desk-top use, this machine makes instant electric copying of letters, bulletins and other single printed or written sheets more readily accessible than ever before.

The new machine operates on the same completely electric, completely dry principle as other "Thermo-Fax" brand copying machines, but meets more personal copying needs. The new desk-top model will fit in with the decor of any office. The "Courier" copying machine is smaller in size, lighter in weight and more compact than other machines previously available.

It weighs only 25 pounds and is 4½ inches high, 12½ inches deep and 14½ inches wide.

The new machine has only one control for simple operation, yet copies the same wide range of inks, pens, pencils and printing that other "Thermo-Fax" copying machines do, and with the same speed and clarity.

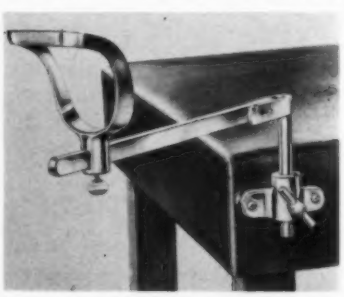
Write for complete details to Minnesota Mining and Manufacturing of Canada Limited, London, Ontario.

"K" Stirrup Added to Profex Line of Surgery Equipment

The addition of a new "K" Stirrup to their line of equipment has been announced by Professional Specialties, Inc. It can be added as an accessory to the Profex line of examining tables or to any wood examining table.

A unique mechanism locks the stirrup securely in place when in use. The stirrups adjust laterally as well as along the length of the supporting bar.

A slight lifting action releases the locking mechanism and the stirrup can be dropped to the side of the table where it is completely out



of the way and will not obstruct the physician during the examination of the patient.

Additional information and literature describing the "K" Stirrup is available from Professional Specialties, Inc., 1920 South Jefferson St. Louis, Mo.

New Gas-Oxygen Analgaesia On Clinical Trial

A prototype gas-oxygen analgaesia apparatus, specifically designed for maternity patients, is presently undergoing clinical trial in several

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Across the Desk

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large maternity hospitals in the United Kingdom.

The equipment developed by the medical division of British Oxygen Gases Limited in conjunction with leading British medical authorities, will be available in Canada through British Oxygen Canada Limited, Toronto.

Company spokesman point out that the emphasis in the design of this new apparatus is on safety and reliability. The machine delivers mixtures of nitrous oxide and oxygen, which can be varied by the operator between twenty per cent oxygen and eighty per cent nitrous oxide to one hundred per cent oxygen and as the patient dictates while in labour.

In the event of failure of oxygen supply, the nitrous oxide is automatically cut off and an air inspiratory valve comes into operation. Minimum intake of oxygen is twenty per cent and operation of an emergency press button provides an immediate and sustained supply of pure oxygen, regardless of the mixture setting.

Low-Cost Scintillation Scanner Introduced By Picker

A low-cost scintillation scanner that provides highly defined scans, while subjecting the patient to smaller doses of radiation, has been announced by Picker X-Ray Corporation.

The Picker Cliniscanner has three unusual features that enable it to produce more clearly defined scans.

A contrast circuit makes it possible to emphasize small relative differences in radioisotope concentration and to minimize the effect of background radiation on the scan. Reading of scattered radiation is eliminated by a pulseheight analyzer that records only the peak energy of the selected isotope. And, finally, "halo" is eliminated by a three-inch lead detector shield, which also contributes to reducing background and improving collimation, Picker explained.

Since recording is made by electrical impulses, the entire recording operation is silent. The Cliniscanner may be set up on a mobile floor mast or mounted on a wall bracket and is motor driven for vertical and horizontal travel in either mounting. Scan area is 11 x 14 inches, large enough to cover all body organs.

The scanner may also be used for uptake measurements with the use of a flat field collimator.

Further details available from Picker X-Ray Engineering Limited, 1074 Laurier Avenue West, Montreal.

New Appointment At Royal Metal Manufacturing Company

The appointment of Harry Whitehead as divisional sales manager of the office furniture division of Royal Metal Manufacturing Company Limited, has been announced by Russ Nixon, general sales manager.

Harry Whitehead

Harry Whitehead is particularly well qualified for this work since for two years he was Canadian sales manager for Arnot and, when that line became allied to the Royal Metal organization, he was then in charge of sales co-ordination for Royalite Metal Furniture Company Limited, a subsidiary of Royal Metal. Mr. Whitehead will be at the Company's head offices in Galt, Ontario.

Germa-Medica Surgical Soap In Aerosol Dispenser

Germa-Medica surgical soap with hexachlorophene, long used by surgeons for pre-operative scrub-up, is now available in a 15-ounce aerosol dispenser can.

This new aerosol packaging method provides much greater flexibility of use of Germa-Medica with hexachlorophene. It is now easy, practical and economical to use Germa-Medica throughout the hospital, even in patients' rooms. Physicians and dentists also have found the new dispenser ideal for use in clinics and offices, and in patients' homes, on house calls.

A light touch on the button on the top of can produces an abundance of foamy Germa-Medica. Since the surgical soap is released from its original container, and need not be transferred from vessel to vessel, aseptic control is rigid. An greater economy is also possible through the use of this new packaging idea. Less of the soap is needed for effective cleansing; and the aerosol container can be used in several locations, in contrast to a stationary dispenser.

Write: Huntington Laboratories Limited, 86 Parliament Street, Toronto 2.

Hospital Sheeting At Half Its Former Price

A recent announcement by Duplan of Canada Limited indicates that their Silcote hospital sheeting is now available at approximately half its former price. In addition to the price change, the new Silcote is now available in the popular shade of surgical green and it has undergone several important improvements.

These dramatic changes have been brought about by the increased demand and increased volume for this item, now enabling Duplan to set up their mills for the production of Silcote on a mass production basis, which has in turn brought about many production economies. These economies are being passed on directly to the hospitals.

Silcote has now been tested and proved in actual use for over one year by leading hospitals in both the United States and Canada. The results, though satisfactory in every respect, have none the less inspired several improved modifications by the Duplan research and development department, making Silcote sheeting of even greater importance to hospitals and institutions.

The new Silcote is available through leading distributors of hospital equipment and supplies throughout Canada.

Lightweight Resuscitator Valuable First Aid Device

A new lightweight resuscitator, introduced by Canadian Liquid Air Company, is creating widespread interest in both medical and recreational circles. Called the Pulmonator, and not bigger than a football, it permits the operator to inflate at intermittent periods the

(concluded on page 118)

SUPER FLAKER above is one of 109 Scotsman Ice Machines supplied to six Memphis hospitals by Memphis Automatic Ice Machine Co. Note handy waist-high bin and free-flowing ice flakes.

109 SCOTSMAN Ice Machines in Modern Hospital Center!

More and more hospitals throughout the country are modernizing their ice supply systems with automatic SCOTSMAN Ice Machines. Take Memphis, Tennessee, for example. In the six modern hospitals pictured, you'll find 109 SCOTSMAN Ice Machines making pure and perfect ice conveniently available at the point of actual ice use . . . and with 24-hour-a-day dependability! Many other leading hospitals, both large and small, now employ the SCOTSMAN System for a modern and economical ice supply.

St. Joseph Hospital

Baptist Memorial Hospital

University of Tennessee Medical Center

John Goston Hospital

La Bonner Medical Center

Methodist Hospital

Wouldn't your hospital, too, like to get the full facts about SCOTSMAN?

SCOTSMAN

Modernize with Modern Ice!

ICE MACHINES

YES! Please send complete details, including new "Ideas on Ice" booklet on Scotsman Ice Machines.

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ADDRESS_____

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Mail to: SHIPLEY CO. OF CANADA LTD., Rexdale Blvd., Toronto, Ont., or, TAYLOR-PEARSON-CARSON, 1000 Richard St., Vancouver, B.C.

Across the Desk

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lungs of a person who has ceased breathing. It weighs less than 1 lb. and is ideally suited to emergency application in hospitals, ambulances, police cars, emergency vehicles and for many other first aid groups.

Consisting of a specially designed self-inflating rubber bag with valve and face piece, the Pulmonator is operated by gentle manual compression. It is designed primarily to supply air, but it may be connected quickly to a cylinder of oxygen by means of an inlet at the end of the bag.

The most important component of the Pulmonator is the modified 90° Lewis Leigh non-rebreathing valve which prevents the escape of air during positive pressure inhalation and also acts as the avenue for the escape of exhaled air. The one-way inlet valve also incorporates an oxygen nipple whereby oxygen up to 40-45% of the total mixture may be added by attaching the nipple to a suitable oxygen supply.

Wood's Introduce Upholstery Shampooer-Vacuum Unit

The industry's first machine to combine both scrub-shampooing and vacuuming functions in one unit has been announced by G. H. Wood & Co. Limited, Toronto. The machine is designed for use on upholstered furniture, carpeting and automobile interiors.

The new upholstery "Shampooer-Vac", weighing only 38 pounds, is portable with a 30 ft. No. 16-3 non-marking, rubber covered cord permitting a wide range of operation. Hoses carrying foam shampoo to the brush head are of vinyl plastic, 10 feet long, alkali and acid resistant. Hoses are equipped with snap-on fasteners for easy attachment and removal. The shampoo brush, 3½" in diameter, is nylon filled fibre and weighs only two pounds. Tanks are of stainless steel construction, non-rusting and non-corrosive. Top castings are highly polished aluminum alloy.

Wood's report that the vacuum motor is the only moving part and

that elimination of a pump in the dual unit practically eliminates "down" time.

The unit is furnished with a wire basket for easy transportation of hoses, brush head, vacuum hose and shampoo.

Further information on the new Wood's upholstery shampooer machine is available from G. H. Wood & Co. Limited, P.O. Box 34, Toronto 14.

Chairs in Modern Trend for Patients' Rooms

An improved version of the popular arm and side chairs for use in patients' rooms and many other areas in the hospital. These new chairs feature plastic seats, backs and arm rests, in addition to spring steel back support for added comfort.

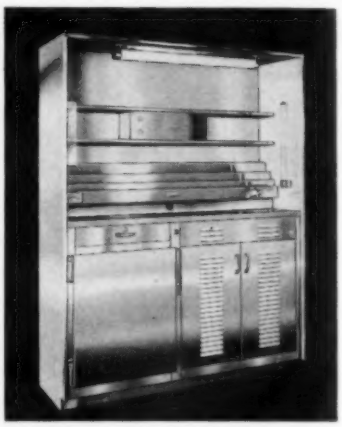
For full particulars write any office of Contract Sales Service, Eatons of Canada.

Market Forge "Medi-Prep" Medicine Station

The Market Forge Medi-Pre medicine station, which has becom standard equipment in nurse stations, is now available in a 60 wide unit.

This larger model is ideally suit ed for the hospital or nursing hom which has more than an averag number of beds per floor. Th greater width also greatly facil tates ease of instruction.

Twelve inches wider than the 48 model, this new unit also conbine in an attractive, sanitary stainles steel cabinet a 4-cubic foot refrig erator, sink, with push button wate faucet, carefully designed tiere storage shelves, a double safety-loc



narcotic cabinet and many other time, labour-saving and safety features for the storage, preparation and dispensing of medications.

Complete information on Medi-Prep units will be sent on request by writing to Market Forge Company, Hospital Division, Everett, Mass., or to the Canadian distributors—The Stevens Companies, Toronto.

Emergency Power Brochure Released By G.M. Diesel

An attractive new 8-page brochure illustrating G. M. Diesel's complete line of Diesel-powered standby generator sets has just been released.

Entitled "Emergency Power for Hospitals" the new brochure gives complete specifications information on G. M. Diesel's single and multi engine generator sets.

Copies of the brochure may be obtained by contacting G. M. Diesel distributors and dealers or by writing to General Motors Diesel Limited, London, Ontario.

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